Archives of Dermatology and Syphilology

VOLUME 36 DECEMBER 1937 NUMBER 6

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THE PROCESSES AND ORGANIZATION OF GRADUATE MEDICAL EDUCATION

PRESIDENT'S ADDRESS

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I propose to talk today in the harsh dogmatic phraseology of a field officer who has spent twenty-eight years of his life on the educational front of medicine, twenty years of it in posts of responsibility. I use the military terminology intentionally. I have become convinced that the struggle for the advancement of knowledge, on which the right of a discipline to recognition fundamentally depends, is, as Krogh has said, a guerrilla warfare against the unknown. In that warfare the attributes of the individual mean far more than the maneuvers and discipline of the mass. I have been interested in the development of the individual soldier and am today deeply concerned that he be not too much machined in the current moves toward organization of graduate training and licensure for practice. It is of him that I would speak, holding his selection, his training, his accomplishments and his possibilities as paramount. Only as it contributes to him do I consider organization of any significance at all, as an instrument, as a means, and never as an end in itself.

While I am about it, I shall—for purposeful guidance and training require it—consider the situation of dermatology today, here and abroad, and the kinds of dermatologists that are needed, as preliminaries to any ideas on how to produce them.

Dermatology is an offshoot of medicine and developed by the typical phylogenetic route. Its practitioners began by selecting a structure and to its gross abnormalities of appearance applied names, sufficiently esoteric to defend their territory against casual invaders. That there is nothing reprehensible in this land-grabbing technic is attested by its universality in human activity, the medical sciences (anatomy, for example) among the rest. From this first gross primi-

Read at the Sixtieth Annual Meeting of the American Dermatological Association, Inc., Cresco, Pa., June 3, 1937.

tive form, developed by analysis and classification and protected by vocabulary and shop talk, dermatology progressed promptly to the second stage, applying the microscope to its structural terrain to produce cutaneous histopathology in the static or anatomic sense. Up to this point progress was facile and rapid, for many can describe appearances and quite a few can analyze them and picture them with the aid of technical processes, such as sectioning, photography and reduplicatory (not interpretative) art. And nearly all students can label and do so with delight, feeling their oats in the doing.

But at this point a subtle but critical situation impends. The structural possibilities are being exhausted by analysis and cataloging. Where shall alert minds, not satisfied by what is now a traditionalism of static entities and their nomenclature catalog, turn? Where indeed but to function, the "particular go" of things, the study not alone of what they are but of how they work. And this transition is critical, as the evolution of anatomy showed thirty years ago and that of dermatology shows today. The shift is to function—first to gross functional relations and later, but just as inevitably, to minute function, physical, biochemical and micropathologic. The old science remains the root and the trunk, the groundwork and the supporting frame but the synthesis, the growth and the perpetuation of the science lie in the domain of function.

I do not say it is a higher end or a nobler work, this study of function, which is the evolutionary culmination of a special mode or field of thought. But I do say it requires of those essaying it a different, a distinctly different, mode of thought. The fertilizing ingredient or stimulus is imagination—*Geist,* the Germans called it in the day of their glory. It demands power to synthesize as well as to analyze, to picture change as well as fixity. To predict soundly on the basis of observed fact and to integrate rather than merely to dissect and analyze are the faculties that carry the specialty over the line into the creative, the commanding advance.

Why do I emphasize these things? First, because dermatology, in this country especially, stands like a tree about to put out bud and leaf but having as yet put forth neither to the full measure of its promise. You who have trees you love know that moment of anxiety that comes each spring. Will the tree bear few or many? Will every branch and twig bud and flower? So it is with us who love our work. Is it to bloom into function and self-perpetuation this year, or is it not?

Secondly, I emphasize these things because to bloom thus requires evolving, progressive minds and intense specialization within specialization. The simple days—the naive days of seeing, describing, naming and reporting—are gone. Today we who teach, practice and lead must advance ourselves beyond diagnosis and labeling, beyond clinical

differentiation and microscopic description and beyond empirical treatment. In making the critical transition into function, we must begin to reason by physiology, return essentially to medicine and think in terms of the relation between organ and system, of the total person, of analysis by factors, of multiple instead of single cause etiology and of the interplay of the normal and the pathogenic. We must be thinking how this becomes that—not merely what this and that are. We must see the picture in motion not merely frozen over a name. And having thus long and ardently thought on the broad fundamental background and interrelations, we must attack the minutely and intricately functional in the laboratory and on the patient.

I emphasize again two things: First, if we do not grow beyond the staticism of anatomic and histopathologic dermatology, our cannibalistic mother, medicine, will devour us. She is already in this country showing the restive impatience that precedes the reabsorption of a weakling offspring. No bawling claims to our right of identity, no waving of case reports, no thick textbooks representing undigested catalogs of disease will stave off the day when bright young internists, trained in the laboratories of physiology, chemistry and pharmacology and accustomed to walk the wards as students of disease in general, will be the successors of the few remaining professors of dermatology. Second, unless we who are teachers encourage, inspire by example, and actively seek new integrative minds, better stuff for training and better training for the stuff we get, we shall not pass.

A host of painful thoughts, of *mea culpa,* wells up in my mind as I reflect on these things. American dermatology, great by the standards of early days, has of late been busier calling itself great than proving its claims. The dynamic stimulus has come from without; and only in the latest years, and then too often only indirectly, can a minimal case for the contrary be made out. Functional histopathology is today the domain of Gans and Pautrier, and physiology, of Krogh, Lewis and—to save our faces—perhaps of Peck and Cornbleet. Who published the most recent comprehensive studies of sudoral physiology? The Japanese. Who showed a grasp of tuberculosis from which internists and sanatorium gods should take lessons? The lamented Jadassohn. Who showed as but one item of his many accomplishments that allergens need not be proteins? The lamented Bloch. In what literature do we read the almost tragically futile summations of the naïvetés of blood chemistry in relation to cutaneous disease? In the American. Who attacked the problem of histamine? Thank God, a now unremembered American who all but shocked a dermatologic society in my youth by reading a presidential address on it—the lamented F. G. Harris. But what dermatologist continued and extended the work? None. In whatever direction one turns it is shockingly clear that the bridge into

the functional dermatologic promised land is not yet of American architecture and contains little American brick, stone or steel. More than that, it is not of late fundamentally even of dermatologic architecture. Cutaneous temperature is the field of Bazett; the vascular physiology of the skin, that of Lewis, G. E. Brown and Sheard; cutaneous neurophysiology, that of Leriche and Adson, and cutaneous chemistry and physics, that of Stevens, who has done the recent beautiful work on the oxygenic mechanism of lipid bactericidal action under ultraviolet irradiation. Such questionings, many and partial though the answers may be, lead inevitably toward the one question with which the future of educational work in the field, as I see it, is so inextricably tied up: Who and what is the dermatologist, the great dermatologist of today and of tomorrow? Is he a mental catalog of colored plates with esoteric descriptive designations and an index, complete down to the last described case of the least significant of ailments, alphabetized because his field, forsooth, is so disordered that only this most primitive of stone axes can be set to dub, hew and put in order its tangled and windfelled timber? Is he a catalog of prescriptions and formulas, added to monthly as the sheaf of pharmaceutic house organs rolls from the presses? Is he a genie of chromium and wire, sitting in a tangle of gadgetry, pulling this and pressing that, shooting electrons now here, now there, to the destruction or mending of he knows not what or how? Is he the gentleman, classically educated, who knows by instinct whether a term ends in "um" or "a," though of alpha or omega in the fundamentals of a disease complex he has no knowledge deeper than the surface? Is he the good mixer of spirit and of cocktail, whose selection of vintage, cigaret, stud and stick is impeccable and vital to his membership? Let us not forget the story of the cherry pie and the chair of medicine, more significant almost than that of the cherry tree and the hatchet as an example of a technic of human evaluation. Which of these shall a great dermatologist be, which possess and which carry as his distinctive mark? Let him have all I have named if he can and will, but only as incidents and impedimenta for his hard journey into strange and adverse circumstances and environment. Stripped of these incidentals, let us find in him an intellect, a brain which none of these trifles can captivate, absorb or stultify, though he may use, and let us hope often sweep aside, all these and many more, as he thinks his way through to the core of his problem.

The need of today, then, if we as teachers are to justify ourselves and remain to till our ground at all—to say nothing of harvesting our planting—is better brains, better aware of where the significant lies and better equipped to reach it by more synthetic and constructive thinking as well as by more intricate and methodologically perfected processes of technic. It is to the enticing, the selection, the inspiration and the gui-

dance of such minds that we should be setting ourselves. Small will the gathering be, for of such seedlings there are few, but great will be the towering of the oaks therefrom.

The attracting, encouragement, equipping and guidance of superior minds being then our chief concern, it is the duty of each agency in the field to study each move it makes in the light of this obligation. Systems and methods of selection for and conduct of schooling and training; the personnel, equipment and material of teaching and investigative centers; the standards raised as barriers, the steps by which they may be climbed, the aid and comfort furnished by societies and organizations for group effort; the provisions for progression and perpetuation of the advance of knowledge and the rewards of distinction—all must be examined and coordinated in a planned economy for achievement. Some remarks on these items will make up the rest of my address.

At the start I propose certain principles that will be useful in comprehending the development of the individual adept mind, as they are in comprehending the growth of a science or a specialized mode of thought. Following Baer's law, the ontogeny of the neophyte in the specialty repeats the phylogeny of his science. He must of necessity concern himself at the start with the gross morphology, the taxonomy and the nomenclature of his field. Then, with this and the foundational—what one might call the H and E—histopathology of his specialty, he completes the structural cycle, establishes root, trunk and branch and is ready to take the springtime leap (if he is of live stuff and capable of it) into function. He then begins to integrate as well as to analyze, goes back to medicine and the basic sciences in principle, thinks out his etiologies, speculates, probes, collects material and sifts, in search of fundamental causes and interrelations. He is now a functionalist, part of the advance, the front of his specialty. And on this functional front he finally uses, or in a flight of distinguished originality devises, a method for the penetration of the hitherto unpenetrated. This is his culminating effort and achievement, his crown of glory. He, indeed, even if he does so only once, has flowered, justified his being, made a rough place plain.

This being the course, it follows that selection, rating and emphasis must be adjusted to it. Let it be clear that there is use and need for those who do not pass the structural, the descriptive and the classificatory levels. Their landmark is the correctly identified case and its report, the accurate account of what is but not why, the instrumental perfections of photography, macroscopic and microscopic. Just as this is the most elementary as well as the most fundamental of achievements, proof of it is to be expected of every allegedly trained man; nor should the credential of the case report be rated above its value, merely because

of number, rarity, hyperscrupulosity in descriptive or nomenclatural detail or the appendage of a merely enumerative catalog of uninterpreted literature—the lienteric diarrhea of pseudoscholasticism that precedes or follows the report. For all such are essentially irrelevancies. I do not underrate the passing by the student of his first test of basic structural proficiency and knowledge. But when it is turned in, I search it to the combing of the ashes for the spark of functional grasp. For grasp is different from mere knowledge. It is knowledge seized as a tool and swung back on the problem. Many case reports are labeled *zur Kenntnis,* but few indeed are chosen. The integration of case material with functional or etiologic explanation is the first gasp, the birth cry of truly constructive thought; and it is toward this that one urges those of whom he expects or hopes for the beginnings of distinction.

Beyond the case report lies a land of promise, harsh and rugged if explored for the gold or diamonds of function, and smoother and less variegated if the less specialized forms of accomplishment are pursued. To explore that land, what does the competent brain need to fit and aid it for its job? Is it the ability to mix a cocktail well or to spew cherry pits appropriately? Perhaps, if the art is to be that of pleasing social cooperators and attracting sources of funds in ties and tails. But more critically speaking, I should say the choice of tools more often lies between an equipment of facts and one of methods or between one of thought and one of instrument.

In preparing minds to attack problems in either broad or minute function, I have been impressed more with how few facts are needed for a good start than with how many. There is such a thing as factual lumber, such a thing as the encyclopedic nonproductive mind, such a thing as knowing too well too much of what other men have done and thought. A blunderbuss loaded with everything from flatirons to carpet tacks is not the weapon with which to perforate the armored steel which surrounds real problems nowadays. I therefore insist on high initial energy, intensity of concentration, grasp of what one has and control of factors—which is essentially aim—as the fundamental prerequisites to a bull's-eye. I do not teach facts per se, except to hacks and encyclopedists, as one loads donkeys for a long trek. I do not belittle the accepted fact, but I emphasize knowledge of where to get facts, rather than mere knowledge of them, as vital to advanced work. Yet I do place high value on the fact-evaluating mind, which synthesizes working theories from known items of observation, makes life pragmatically possible and provides the sharpened picture in the finder, with which one can aim with certainty for a hit.

I am therefore querulously distrustful of curriculums for the training of advanced thinkers. If a school, a graduate school, is to mean mostly curriculum, I expect as little of it in distinction as I do of marble

columns and storied towers as an instrument of learning and research. I could draw indefinitely on metaphor to express my conviction that it is no business of advanced education to supply, or at least to stress, its fact-pouring and pumping mechanism. One hundred hours of this and six of that, especially when the former is histopathology and the latter physiology, expresses rather the deification of code, stasis or individual prejudice than the provision of facilities for advanced thinking in a medical specialty. Again, I do not belittle knowledge; but the ability to get it for himself without courses or curriculums differentiates the advanced man from the beginner and the dub, and emphasis on that ability, the graduate training center from the technical high school. Pari passu, the authority, by whatever name called, whether faculty, board or bar, which busies itself with setting up mere factual hurdles for advanced minds to leap to qualification, is operating at the dub-sifting level, pulling its standard down to that of third year medical school, even for public protection. Perhaps this is the point in our intellectual pilgrimage at which a board should stand, but it is not the place for an agency of functionally creative thought whose business it is to transform and transmute fact with intellectual method.

And so it is with equipment, with material—clinical and otherwise—and with the instruments of our craft. Just as a field rich only in factual knowledge is dead, or at least moving to a standstill, so an intellectual discipline equipped only or even too abundantly with instruments is often choked rather than fed. For science at large there is good reason to fear the mere buildings, the acres of laboratories, the tesselated pavements on which only hollow footsteps ring, the marble rest rooms in which no urinal conference dare ever stand or sit. Within the past two years I have seen some of the best work coming out of dark cupboards and laboratories so crowded that as much machinery operated upside down from the ceiling as right side up from the floor and in which, as the worker entered, the door itself would barely close. There is a barren quality to the institutional field of onions run to tops, lovely though it is to the eye. From whence came—and still come—the great work and the great men? From the Red Wings, from the Albertas and from under the back steps of great establishments whose marble stairways lead nowhere. It is not, then, a primal necessity in great teaching, inspiration, guidance and achievement to have plant or equipment or patients or staff. One grove and two men (the rest hangers-on) were enough to nurture the glory of Greek thought which has been respected for more than twenty centuries. It can be and it is done today. One Beaumont and one patient did it, where a hundred would have choked the font. The intensive study of the few and of men, not animals, is deeply in need of renaissance. Add to that the demand for study of the commonplace and the prevalent with the

intensity which is too easily lavished on the rare, and the pronouncing of an alpha and an omega on the question of progress versus equipment is near. Dermatology and its trainees especially need such admonitions, for they are confronted with an ever present temptation toward gadgetry in the physical therapeutic and photographic fields. As poor in the powers of the living, striving intellect as a discipline equipped merely or chiefly with descriptive facts is that one which has sold itself to the push-button and the switch.

I made a pilgrimage once, one of a few. I went not to see the man, much as I should have wished it, but to see the great laboratory, the fulcrum, as I imagined it, from which, as from the place which Archimedes postulated, our earth had been moved—the laboratory of Sir Thomas Lewis in London. I had seen Pautrier's and Bloch's superb establishments and come away scribbling on the back of an envelop a draft of my hopeless abdication of my academic chair. It was with difficulty that I found the place from which the most significant developments in the study of the vascular physiology of the skin had all but sprung full blown, as from the forehead of Zeus. What? No kymographions, no tambours, no photo-electric cells, no animals and no *dieners?* Not even a comparator, other than a hand-painted tab kit or two made by Sir Thomas himself. A room, a table, a desk, a few things in drawers, an "ad" in the papers for the patient wanted and the mind of the man himself had made over a major sector of our horizon. On the score of equipment at least, I have never been discouraged since.

I have then, frankly and with an intensity compelled in part by haste, set to one side the mechanics of curriculum, didactic presentation and mastery of fact, the instrumentation of the specialty, all excesses of equipment and personnel, numbers of patients or anything, size of this and of that, assistance as mere assistance and examinations and examining boards as mere police and dud differentiators and sifters—all of them to be thought of simply as appurtenances and not of the essence but of the entourage and trappings of attainment. Having done this and solemnly warned of the futility of material glory, let me recant a bit and speak more gently of the purse, the budget, the endowment, the research foundation and that noblest of their individual expressions, the stipend. There is no one thing more needed than a bare subsistence for the man of brains, and I say "bare" advisedly. Money should be so scarce with him who is to achieve that in his formative years there is no joy save work. If there is pleasure, least of all should it be that of guiding a chassised internal combustion motor or of annexing anything that can wear a no. 5 shoe and a 4 inch peg heel. And should there have been a serious and permanent commitment in the latter classification, no issue therefrom should there be until the fourth year or after. For the period of his training the neophyte is

not in the business of living the broad, well rounded life but in that of becoming a hard, sharp-pointed expert, an intellectual and technical master of his field.

Facetiousness aside, money in minimal amounts should seek, first, going (not prospective or planned) projects and, second, men (not institutions and organizations). When competition for eligible men gets down to the mere salary differential between the available chiefs and departments, the work is prostituted; the hirelings become prostitutes, and the product represents commercialized prostitution of the intellectual life. Achievement in science should then have always an element of the austere and training something of discipleship. Money must be kept on the move into places where work is actually doing and should make life a bit less necessitous but neither easy nor materially pleasurable—such is the hard rule for funds.

From what has been said and unsaid, it will be inferred that I believe the most effective instrument for advanced achievement in a special field is the leadership group with guidance, rather than any system of courses, curriculums, examinations and certifications. The latter system is, to my mind, a mechanism for mass production of a more primitive sort than that appropriate to graduate teaching. I would broaden my statement to apply to the use of institutionalized standards in the development, regulation and rating of graduate training centers. Nothing seems to me sorrier than the attempt now being made to measure fitness for official approval by the number of beds, of hours on duty, of patients and of staff. The best that can be said of it is that it is an inevitable and probably temporary aberration based on American mass ideas of success. It seems to me obvious that the intellectual tone of a service, its tradition, its chiefs and their accomplishments and traditions, the record of the product in the aggregate and individually—the trained men who have gone out to carry on gloriously or ignominiously (for there will be each)—and the work being done and talked and written about, all carefully evaluated item by item and man by man, are the weights and measures of fitness, promise and achievement. It is to such groups and their leaders that we must continue to look for the best we are capable of producing. We dare not delude ourselves into the belief that organization, as such, whether of formal schooling or of critique and censorship of the product, can in itself supply the fundamental dynamic force that makes great men or inspires compelling or influential thought.

Call this concept of advanced education and qualification by any national name you will; this type of creative education places a huge responsibility on group leaders. It is nonetheless not only the best mechanism for the development of the individual fighting or achieving man but the ideal one for the perpetuation of the dynasty or tradition

of leadership. Here is one situation in which aristocracy and democracy combine—democracy as the source of raw material and aristocracy as the source of guidance. As one who has had the fortune to live under both types of educational and medical régime, I tend to subscribe to the benevolent despotism of the official family and the leadership group when genuinely and informedly benevolent, as against the pseudodemocracy of the school, the faculty and the staff.

I cannot resist an exchange with you on the functions and problems of a chief—a group leader, or purveyor of guidance, as one might more polysyllabically call him. Like the good executive as once described, he should not be too virulently outstanding. He must particularly keep keep down his proclivities to dominance. His function is to induce others to do even what they believe sincerely they cannot, for in that direction lies power to grow against self-inhibition and external obstacle. His functions mingle the intimacies of personal counsel and conference with an obnoxious inopportuneness of detection of personal fault and correction worthy of the military police. Conference is his chief problem. No chief I have ever known has had enough time to give to it, regardless of his official assignments or personal schedule. On duty, he must hear sympathetically and know equally well when to ignore, when to act slowly and when to strike. In making decisions no rule seems so serviceable as that of maintaining a twenty-four hour interval between impulse and action. So much of the thinking of a consultant—which is what a chief is in the last analysis—is subliminal, that instant action rarely uses a man's full intellectual force and maturity. To learn to trust, love and believe in men, especially young men, was one of the truly great things I learned from Dr. Will Mayo—that and to give each his head, his chance. "John, you're the chief" still echoes in my recollection today, through many a moment of contact with my later associates.

The next great problem of the chief is that of delegation. It is so tempting to use prestige in persons, so hard to forget in the interests of the balance and development of one's co-workers and the economical use of one's self the satiric-sardonic maxim, "If you want a thing well done, do it yourself." To be humane and considerate in speech and act—it was on this in a specific instance that the elder Jadassohn put his finger when I boldly asked outright for the secret of his extraordinary and continuing influence and inspiration in his group. One of course tends to construct a picture of the ego-ideal as he describes the chiefs he has known, but the element of affection, the unjealous gift of untrammeled opportunity, the fairness, the justice, the clarity of matured decision, the deafness to whisper, rumor and gossip and the high hope and faith in men, while the actual expectation is kept within reasonable bounds, all are of the essence of chieftainship.

A chief performs in the group many of the functions of an accoucheur. Though he has not created the personality or the solution to the problem, he assists in bringing it into its world. He should never by the part he thus plays confuse himself with the father nor stir up between himself and his associates the perilous forces of the father-son rivalry, a principle many a chief, in a moment of proprietary weakness, forgets to his undoing. Not even so modified a simile as that of elder brother to his associates expresses the feeling tone of the relation of chief to associate. Paradoxically, while it is the talisman touch of the family that makes staff life so rich, stimulating and happy, yet too much of it defeats the dispassionate insight and impersonal skill in the unfolding of personality that enables the relation of chief to associate to bring each party to it again and again to his full measure and possibility.

The relation of chief to associate has to deal with one of the most sensitive and precious mediums of human exchange—intellectual property, one might call it. Nothing is more important; nothing must be kept in higher purity than a chief's relation to the intellectual capacity and accomplishment of his associates. That is their most precious heritage—unpurchasable at any price, entitled to a full and just, indeed a most generous, recognition at all times. It is a privilege inherent in the relationship to give to associates, and to be allowed to make a gift to one who will transmute and transfer that gift, enriched by his own powers, to the world is as precious a privilege as there is. How then make it the basis for a claim on the donee, to be satisfied by so many dollars a month or by thus and so many items, papers and researches of unpublished, unacknowledged or insufficiently acknowledged authorship? In no part of the group relationship does a fine sense of fair play reveal itself more than in the truly distinguished European tradition by which group directional influence and tradition and the chief's responsibility are acknowledged in a footnote, while the author stands out with his title in just relation to the material and workmanship. The recent practical working rule established by my associates and me has been that the single case report, especially the first, should be solo. Collective or group material is usually written collaboratively, the senior authorship going to the man who most influenced the thought and the collection of material for the study. When a special method is employed, the weight or grading in seniority goes to the devisers of the successful set-up and the supervisors of the work, rather than to the author of the idea on the one hand or the hacks on the other. In other words, seniority goes with synthesis and is a reward for constructive thinking rather than mere flash inspiration or technical performance. He who puts his idea all the way through the machine by years of either clinical record keeping or of chemical analyses reaps top recognition.

Among the incidentals of being the chieftain there are items familiar to many of you, such as the hunting up and down of funds, the prodding of indolence, the smoothing out of misunderstandings, jealousies and piggishness and the working up of cooperations between departments and in special sciences. Indolence creeps in through every loophole—afternoon tea and friendly visiting diversions, club reactions with prep school snobbery, smoking room gossip, laboratory hang-outism and finally week-endism and vacationism. The grape-vine telegraph spreads demoralization, and the payroll upheavals shake the departmental earth. But in a changing, active service the stars move in their orbits to a new concatenation; the old order and personnel roster change, and the crisis fades. General problems worthy of the best one has to give them appear in the maintenance of records and notes at research levels (most clinical records are junk) and the surveying of the field for lines of work appropriate to the budget, the existing facilities, the available brains, the accessible cooperation and the time for action and completion. Cooperation from experts is a double-edged help, for in a service where a man must be trained to become the jack-of-all-trades which is an unendowed young dermatologist heading for practice, the maintenance of continuous or even major intermittent effort in one extramural department besides one's own is a problem against whose hard face the friendship of the cooperating scientist is often shattered. Yet such cooperation is, I fear, for some time to come, the only safe attack for us as dermatologists to attempt on our most fundamental problems of microfunction and special method. To attempt them alone in one's own laboratory, granted one has one, is too often to waste months or even years of effort on an untrustworthy method, invalidated at the start or soon after by control factors that only an expert could have pointed out or recognized as the work progressed. The adventure into fundamentals, even of such chemical analysis as Bloch undertook in his work with trichophytin, is perilous in inverse proportion to the equipment, accessibility and interest of chemical or other consultants. The ability to get a laboratory does not imply the power to use it or to interpret the results of its use intelligently. Merely to be able to hire a chemist is no solution, if the man is merely a technician. Such technicians betray one into false security, pronouncements and generalizations that often do not outlive their publication. Let us hope there will come a day when a prospective dermatologist, in his own right an adequate special scientist, joins our staff; and meanwhile let us seek linkage with the tolerant among the laboratory men who have either liberal budgets or the simpler equipment for study of our problems.

There is in all groups a slowly accumulated stock of special interests, special knowledge and material and special problems arising from them. This I call the "barrel," and it must be fed, and kept filled, with prob-

lems, especially, that have a quality of common property based on their birth from the same general material and tradition. Every man is expected to pool some vital part of his ideational resources in this barrel. It is a breach of honor to use this material without acknowledgment, to apply it in practice without making adequate return in kind or in other new ideas, to work it up "outside" and secretively to publish the results without laying the plans and work before the chief, to take the work elsewhere without permission when one leaves or to hold indefinite claim to it without performance. It is out of this sort of barrel that the field, the line and the vital tradition of a group are made, and responsibility for it is for the chief a seldom adequately performed and always worrying task.

And now enough about the chief. What of the man (or woman) who as a member of the group must pass through the novitiate and prepare for the career of a distinguished leader, so far as in him lies? In his hands, as Ecclesiasticus said of the physician, is the issue of life, and in the handiwork of his craft is his prayer. The selection of new men involves, of course, assurance of their elementary fitness and training, but it implies much more. First let me, for the record at least, lay the perennially reviving ghost of preparation for distinguished attainment in a specialty by five years or so of general practice. In general, I hold there is no worse preparation for specialization than the general practice of medicine, so-called, today. A year of it teaches technic at the telephone, some knowledge of human nature, how to furnish an office, how to keep the competitive knife from turning in one's back, what to carry in a bag, drug store etiquette and the gullibility of man. Five years, more or less, of it trains the victim to superficiality and inadequacy of examination, haste, bluff, reliance on the stock prescription, shotgun therapeusis, catch-as-catch-can and guesswork as a substitute for reason. Many general practitioners need to unlearn from the bottom the methodology of their work before they are even receptive to the idea of intensive analysis, of thinking through to the logic of a question that marks the expert. I am not speaking of ward walks under the guidance of a master or even of a glorified internship. In general, the specially fit man is prepared by contact with distinguished men, not courses or hours of this and that. Foresightedly, he will have acquired special knowledge of scientific thought processes and of a basic scientific method, in addition to or as an expression of a habit of clean-cut thinking.

The ideal candidate may be differentiated along the lines, first, of the incurious versus the curious, then of the casual or cursory versus the penetrating, and finally of the indolent versus the energized, determined and indefatigable. Flash brilliancy may hide lack of power to carry on through absolutely inevitable and unvarying drudgery to a

significant finish. Enthusiasm has its place across the table from phlegm. Absorbers early differentiate themselves from explorers, and because curiosity and exploration are, with energy, so large a part of *Geist,* I may undervalue the merely facile learner. Other distinctions include that of readers versus writers and of bookmen versus labmen—but not that of clinicians versus investigators, for there should be no exclusion of the one by the other, laboratory or none. Among the valuable unofficial guides to intellectual classification are publications, fraternities, recreations and dependents. Weigh twice a young man who cannot use the typewriter, who speaks and reads only one language easily, who has a wide range of amusements and who leans toward light reading, the theatre, golf and bridge. The bright but lazy and distractable man can reduce a whole eyrie of eaglets to a "passel o' squabs." Insist on a personal interview, and in it try to picture the candidate as an influence, for the tone of the group goes as far as the personality of the chief in determining what impress is made on the progress of dermatology. Just as men reputedly select women for employment as if they were to be wives, so men tend strongly to select men as if they were to be their club members and fellows in one gang. Diversify therefore; bring in dynamic disturbers; mix the blood. And, above all, fear indolence, and fire for it, for it is a crippling, infectious disease. Only lack of curiosity can take place beside it as an incapacitator.

And having chosen your man, think of all you must bring out of him that no course of lectures or curriculum ever touches. First, he must long, and then learn, to get to the bottom of things. For a real lack of the "'satiable curiosity" that Elephant's Child paid for so fortunately through his nose, especially if added to a lack of thoroughness, men should be dropped at the end of the first year. The ability to observe, as Wile used to say, differs from mere ability to see, for observing leavens the seen with intelligence. There is no better practice for this than intensive drill in description, which succinctly presents selected essentials, winnows the chaff of mere wordiness from the grain of the distinctive, the differentially important, the etiologically suggestive and the pathognomonic. Side by side with training in visual observation the learner must acquire a special history-taking approach to the multiple factors in the background of cutaneous disease; for I no longer find it possible to accept as adequate to full functional analysis the purely objective study of the patient's appearance which has been the morphologic dermatologist's distinctive practice. The acquiring of these two essentially elementary methods goes side by side with the factual review and the acquiring of names and a store of mental pictures that make the bulk of the grind of the first year. The acquisition of the ability to express and to present case material cogently, clearly, logically and even eloquently is essential to the drill, for on it

depends the power to teach, to speak and to write effectively. Training in protocol and record and in the development of statistical tools is part of the first two years, and no discipline, unless it is the stripped examination, is better than insistence on the penetrating, complete and perspicacious progress note. Until a man has tried to evaluate a case from loose description and worthless notes he has not cut his mental eyeteeth.

Six other forms of training fill the second year, as follows: 1. There must be training in projection and imagination—the seeing and full accounting of all the possibilities. 2. Reasoned differentiation must be stressed, and impressionism and street-car, curbstone, snap and flash diagnosis at one extreme, and hyperacuteness, "meticulosity," and the "rarity fever" which makes of every case of purpura one of "annularis telangiectodes Majocchi" at the other must be eliminated. 3. As differential capacity develops it must not leave the student suspended in indecision, for to snap out of a cloud of possibilities with a certainty of identity clutched in one's mental hand is a distinct feat and an indication of a special mental grasp. 4. Side by side with action the student must learn reflection—the mulling and pondering that ripen thought and use the experiences stored in the subconscious mind. 5. Training in cooperative and coordinative effort comes most naturally through a joint collaborative research, especially in the evaluation of statistics and of cases in the second year. 6. With this comes the opportunity for training in bibliochresis—the search for and, what is far more important as well as rare, the power critically to evaluate published observation and opinion. No milk-soaked cracker of library technical assistance should be offered the novice here. He should search his indexes, read his originals, abjure abstracts and compile his own summaries and references.

Here the bookworm thrives and should be held back until he has driven his own line into the field, while the ready writer and originator of impulses should be made to hew out every last item on the topic before he does his plunging ahead. For years I failed to grasp the meaning of controls in full detail. Now, though I still fall far short, I require of every inexperienced research worker a full set-up and diagramming of his experiment and analysis of it for control factors before he lifts a test tube from the rack.

The third and fourth years are the period of maturation. *Erfahrung*, acquaintance and scholarly grasp of the field are the fruits of hard work, rigorous thinking and intensive and extensive reading and discussion, of journals more than of texts. The journal club does best in requiring of each member not a catalog or sheaf of abstracts from multiple journals but a synthesized account of a fully read-up, well digested modern topic, seasoned with critical comment on methods and

ideas. One or two of such per man in a year's grist furnish priceless training in thoroughness, constructive imagination, projection, controls, critical faculty and expository expression.

Drill on the "everlasting why," an instrument of torture for the slack minded, adds a touch of savagery to the later years of work. One might call it the Boot, so everlastingly must it be applied to the sluggishly incurious and unalert and so frequently even to the ablest of men in lax moments and during lapses in thoroughness. The thrust and parry, the calling to account, the challenge and the clash in seminar and polyclinic are what give the quality one of my staff once called "bristling" to a really worth-while conference. Out of the growth-provoking stimulation of this round of training comes a distinctive and distinguished thing—the true consultant personality and acumen. Rarely is it recognizable before the beginning of the third year—a cogent argument for the long as opposed to the short novitiate.

One of my quarrels with the formalized curricular plan of graduate education is its tendency to relegate free thinking, exploration and research to a jackal's place at the lion's feast of routine. Of all teaching instruments, the effort independently to find out about a thing has since I first at the age of 14 years probed the patent records for an explanation of the locomotive's throttle valve, seemed to me the most worth while. From the double poppet I learned the delight of finding answers to my own questions, the true spice of life in all the ardors of one's later years. For it is from his ability to find constant inspiration to research in his daily routine that a man spins the fabric of lasting happiness and content with his lot. The research need not be epochal, hardly of more than personal significance; but it must be habitual, an unquenchable addiction to the cause of knowing why.

For use as a measuring stick of intellectual appraisal as well as discipline, three research efforts carried to publication are reasonably to be expected of the advanced student in a balanced three or four year course. First, logically, comes the case report, attesting mastery of expression, descriptive power, anatomic fundamentals and interpretative grasp of the literature. Then follows the coordinative collaboration, in which Louis' method is used on case records with factual, etiologic and literary interpretative implications. And as the culmination should (but seldom does) come the solo excursion into unexplored territory by the critical and controlled use of a borrowed, modified or original method. Of course, mention of this suggests a laboratory; but a laboratory is by no means indispensable to the independence, the critique and control, the originality in concept or the application of a method. There is still great need for the astute application of simple clinical physiology and analysis to the direct study of the sick human being in

our field, even more than in other aspects of medicine, for so much of our territory is laid open to our senses and to simple indicators.

I have reviewed the problems of the research trainer too briefly, but let me at least mention some that beset the trainee. Outstanding are the difficulties of temperament. Indolence, leisurely habits, a soft or turned edge, distractibility, all lead to empty spiritual and intellectual hands. Procrastination is still the thief of time and brings the training to a close without the thesis all too often. Discouragement with the negative, often quite as illuminating as the positive, swamps some; and inability to slog through drudgery, the inevitable low ground of research, mires others within sight of the heights. Common early difficulties among enthusiasts are the biting off of too many problems—a tendency to go goggle eyed with the wonders—and the biting off of too much in one, as he who perennially opines, when asked, that he would like to do research on psoriasis. Let a man propose his problem; then let him put it in writing, diagram its margins of error and controls, list his equipment and animals and calculate his time and costs, and there will be a man changed for the better, even though he never takes another step. At least he will not again speak with light disdain of the investigative mind and bent.

I have said that organization cannot "do" research—at best it can only encourage and protect the creative mind—in discharge of which function it does well to remember the bugaboo of overprotection and the paradoxically unstringing effect of making life too easy for one who should be the constitutional striver against odds. It is not less true of some minds than of certain tool steels that they cut badly when oiled. But there are some things that organization, in the form of societies, can do for the life of thought—and these, because they interest us today, will be the subject of my closing remarks. The groupings of social clubs, professional and trade aggregations or guilds, honor groups and forums for the exchange of ideas are all active in our field and sometimes strangely mixed. In proportion as a group places social qualities, congeniality, personableness and "mixing ability" high among its desiderata, it is a club. A club tends to be a congregation of the like minded, and its one great, though paradoxical, act of individualism is the blackball, through which is exercised too often the individualistic privilege of excluding one who is too much of an individual. Aggregations of the clubable and like minded are good in their place, but they do well to know themselves as such and not to expect of or impute to their functioning as clubs too much in the way of stimulation and ideation. Nor does it seem wise for them to overstress or usurp the honorary side of society activity, for that way smugness lies and the inevitable defeat of aim that comes from conceiving honor worn over achievement as a garment of uniform color or pattern. Distinction

is polychromatic in the aggregate and often in the individual—a patchwork, assiduously, toilsomely and often unconsciously stitched together, fringed tatters perhaps appearing at the heels, while over the shoulders the garment is practically whole. If a club would have honors on its back, it must select men for patches by difference, not by likeness, must tolerate lunatic disagreeableness and eccentricity in a person's tattered fringe for the sake of the bright plaque of royal purple on his shoulder. In dermatology there is undoubtedly need for clubs, though to me it seems they are essentially social and local rather than scientific and national in their proper activity and place. The craft guild society has innumerable variants, of which the local group comes nearer to the old town-hall idea of autonomous democracy and joint education for the responsibilities of citizen membership than anything we have. The local society in this country has raised many a yearling from gangling immaturity to a fair adulthood, in saying which I raise my hat to one of the great graduate training groups of this country—the Chicago Dermatological Society as I knew it between 1914 and 1924, and, no doubt, as it continues. I have wished and sought for the Philadelphia group distinction such as this, that of a true Forum Romanum, in which the young must be heard with the old, the novice with the professor, all pawing, discussing, contending, accepting and rejecting in an unprejudiced freedom and privilege of examination and communication. While undoubtedly such societies must have a sufficiently large source of clinical supply and while they profit by intercity visiting and combined meetings, there is a point we all recognize at which teaching, learning, stimulation and exchange are swamped by size. Since not all can see or be heard (and unfortunately so), three courses are open in such mass meetings: to call on the grand old men; to single out especially interested and experienced discussers of special problems represented by groups of cases, and to adjourn the clinical sessions as a penalty for planlessness and turn to golf, feasting and crowning with wreaths as a Scotch-Roman-Grecian anticlimax to a defeated modern intellectual mission. The tendency too often seen for larger groups to turn into circuses while smaller ones turn to strong drink and the bedroom conference does not help forward the intellectual aims of a gathering of the guild and does favor that most depressing and dangerous symptom of organizational decay—election by rumor and rejection by innuendo and government by cabal and by semidrunken cabal at that.

Of the honor society it is hardly necessary to say that an aroma of self-appointment to the post and a constant trend toward smugness can send it tobogganing to oblivion. To me there is great weight in the selection by a jury of one's peers, so long as the selecting method preserves the elements of difference, avoids club criteria and technic, hews to the intellectual line and makes the electoral machinery the

youngest, livest, most changing part of the whole set-up, secure from politics and free from the domination, though not the influence, of the autocrat and the elder statesmen. As the head of an organization, I would eliminate the ingratiatingly political mind in this last line of defense against innocuous desuetude—the planting, nurture and selection of new timber. Who is more vitally concerned with graduate training and advanced education in a field than its societies? Who should better know than an honor society that stimulation of possibilities even more than recognition of established merit is the evolutionary goal and the function of the group? The society, like the training group, should seek men in the productive period, elect young men on promise and fire promptly not on nonattendance alone but on nonfulfilment. It, no less than the training group, is concerned with the relative predominance of the structural and the functional point of view, the meaning on its programs of the titles one reads there and the ratio of one type of thought to another, rather than of one geographic location to another. The honor society should be the Spartan mother of a guild—not the pleasantly smiling and sometimes tipsily nodding patron and dispenser of the laurel crown.

I have remarked on odd mixtures in society organization, incompatibilities like club standards and the assumption of honors, mass entertainment and the austerities of the life of thought. I hasten to make truce if not peace with my friends by a not too original suggestion. An intellectual discipline inhabits, so to speak, its whole terrain—its field as its house. Is democratization within that house impossible without loss of the aristocratic tradition and the incentive and power to grow up to and into it? Does it not lie with a single great national society to make of itself a training aggregation organized like the graduate training group, with doors either wide open at the ground floor or policed by a national board with a minimal standard for licentiates? I would see none withheld from possibilities of stimulation and growth if he is allowed to practice at all. Above the young mass of associates or licentiates could be the group of fellows who have shown creative promise or justified their claims to distinction before a dangerously alive and positively electrical elections committee. Still above these and captaining them could be the stratum of *honoris causa* men—active and voting guides, not retiring superannuates and moss-bearded leafless trunks, hollow from the burning. Beyond but no longer above these could stand the not too irreverently designated elders, the deeply respected, admired, beloved and honored, though perhaps no longer virulent and dangerous, heroes of the past, who like the Trojan horse bore within and disgorged to battle from their once cavernous and deeply virile interiors the bronze-clad warriors of the advance. From

saplings, to timber, to man, to stature, to horses, to dust—this indeed would be a polychromic cycle, in mixed metaphor, of the achieving life.

I speak truly when I say that the distinction of being chosen to your presidency was, after my election to this body, the most uplifting and the most unexpected of my intellectual life. Absolve me, I beg you, of a charge of acerbity that might lie against me for the wording of this address, my one major act of office, for no harshness is intended. I am but one who sought to look in the face of wisdom and to tell you what I thought I saw there. Today I have laid my seeing before you, the actual builders, in whose hands is the standard of our faith and of our works, the chalice of our accomplishment displayed before our world. As your president I have but reminded myself even more than you of our responsibility to the future. Let me put it in paraphrase, as Paul did to the Corinthians:

> "Know ye not that ye are the temple
> And that the Spirit . . . dwelleth in you?"

4228 Spruce Street.

EPULIS GRANULOMATOSA

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The mouth constitutes a sort of "no man's land" between the domain of the dermatologist and that of the dentist, and the boundaries of their respective fields are at times indistinct. The case reported here is an example of a condition which was not recognized by specialists in either field or by a surgeon, is mentioned not at all in dermatologic textbooks and inadequately in textbooks dealing with pathologic conditions of the mouth and was finally diagnosed only after a biopsy.

REPORT OF A CASE

Mr. F. T., aged 82, was referred by Dr. Carlyle Ahrens of Artesia, Calif., because of a growth on the lower gum. The lesion had been discovered three days previously by a dentist, after the extraction of five infected, gold-capped front teeth. The patient had not been aware of the growth and did not know how long it had been present. The teeth which were extracted had been sore and had ached for the preceding two weeks. All the other teeth had been removed fifteen years before.

The patient was an elderly man in apparently good physical condition. The mouth was edentulous. In the center of the lower gum, extending for a distance of approximately 2 or 3 cm. along the gum and completely covering it, was a hard and firm irregular fungating tumor, pinkish, superficially ulcerated in places and firmly attached. There were no palpable lymph nodes under the jaw. There was no evidence of leukoplakia within the oral cavity.

The clinical appearance strongly resembled that of carcinoma. A small piece of tissue for histologic study was removed by means of the endotherm knife, and the wound was heavily electrodesiccated.

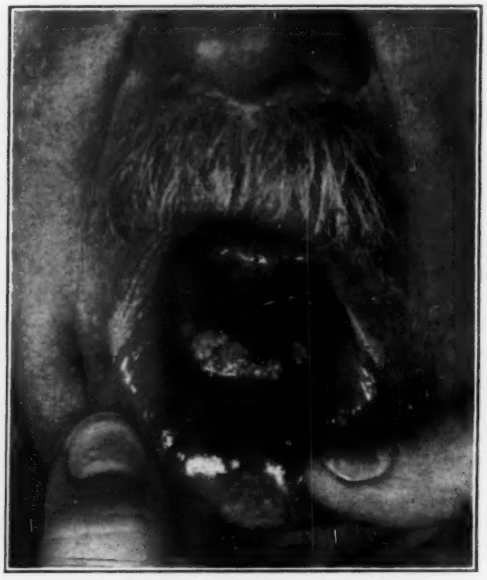
Microscopic examination showed absence of carcinomatous change. There was moderate to marked acanthosis, which was both regular and irregular. The definite parakeratotic horny layer was present. In places the irregular acanthotic rete pegs dipped deeply into the underlying cutis, but the peripheral layer of basal cells seemed to be intact and unbroken. There was no evidence of anaplastic or neoplastic epithelial change. The subepithelial tissue was made up of both loose and compact masses of fibrous connective tissue. Throughout the cutis there were newly formed blood vessels in moderate numbers. There was a rather marked cellular infiltrate present, and this was composed mainly of plasma cells although a few large endothelial cells were present, together with a moderate number of

Read before the Dermatology and Syphilology Section of the California Medical Association at the Sixty-Fifth Annual Session, Coronado, May 26, 1936.

round cells. No polymorphonuclear leukocytes were seen. The essential changes consisted of a chronic granulomatous lesion in which the principal reacting cell was a plasma cell.

A microscopic examination of the secretion from the lesion showed no sign of fungi. An anaerobic culture on Sabouraud's medium revealed only a scant growth of Staphylococcus albus. The Kline test was negative.

The lesion was given three treatments with unfiltered roentgen rays, half an erythema dose each, at intervals of approximately two weeks, and three treatments with radium, in which a half-strength plaque with no filter was used for fifteen, twenty-five and thirty minutes, respectively. A 2 per cent aqueous solution of methyl rosaniline (gentian violet) was applied locally while the surface was ulcerated, and for weeks potassium iodide was given orally because of the possibility



Epulis granulomatosa involving the lower gum, consisting of a rather firm, cauliflower-like growth and simulating carcinoma.

that the lesion might be due to a fungous infection. Four months after the first visit the lesion was well, except for a slight roughness of the gum.

COMMENT

Thoma [1] gave the most comprehensive discussion of epulis granulomatosa which could be found in the American literature, and he described three cases. Epulis is to be regarded as a topographic term meaning a tumorous growth on the gum and may be applied to any histologic

1. Thoma, K. H.: Clinical Pathology of the Jaws with a Histologic and Roentgen Study of Practical Cases, Springfield, Ill., Charles C. Thomas, Publisher, 1934, pp. 344-391.

entity, although it is generally used to designate a fibroma or a fibrosarcoma. Epulis granulomatosa has been designated by a variety of terms, such as fibrous epulis, granulation tumor, polypoid granuloma, inflammatory epulis and gingival granuloma. The condition was described by Thoma as consisting of a mass of tissue varying in size from that of a pea to that of a hazelnut, with an epithelial covering and growing most frequently from the socket of a freshly extracted tooth or from the peridental membrane around a carious tooth. These tumors are attached to the underlying tissue by a pedicle, which sometimes takes the form of a broad base. Newly formed lesions are usually vascular and red and bleed easily when injured, whereas those of long standing become more solid and firm, often losing their inflammatory character and assuming the appearance of a fibroma. If the lesions grow sufficiently large they are subject to trauma during mastication and may become superficially ulcerated. They may recur after removal, but they are benign. The presence of carious teeth, fragments of infected roots, or mechanical irritation from rough teeth or poorly fitting dentures is usually regarded as the underlying cause.

According to Thoma, the histologic appearance is that of a granuloma with hyperplasia of the connective tissue and evidence of chronic inflammation. The growth usually arises from the submucosa or the periosteum. If newly formed, it is principally made up of proliferating endothelium, a few fibroblasts and an inflammatory infiltrate. The epithelium either grows over the surface from all sides or else, if already present, proliferates to make room for growth. In older specimens there is a tendency toward fibrosis, and the epithelium becomes very thick, although it resembles the stratified squamous epithelium of the oral mucous membrane. Often there is a marked hypertrophy of the epithelium in long irregular strands, extending into the underlying tissue. Cornification of the pavement cells is not uncommon. If ulceration of the surface occurs, this may be the cause of renewed inflammatory reactions and sometimes the beginning of malignant change. In general, Thoma stated that epulis granulomatosa is an inflammatory hyperplasia rather than a blastoma. Under certain conditions, however, a fibroma, which may be subject to irritation and ulceration such as commonly occurs in the mouth, may undergo inflammatory changes which make it difficult to distinguish from the former lesion.

Figi,[2] under the name inflammatory epulis, described a case which Thoma regarded as an example of epulis granulomatosa. Figi's case

2. Figi, F. A.: Multiple Pigmented Papillary Nevi of the Face; Pigmented Mole of the Face; Recurring Epithelioma of the Face; Inflammatory Epulis; Fibro-Osteochondroma of the Mandible [case 4], S. Clin. North America **10**:101 (Feb.) 1930.

was that of a man aged 54. The lesion had been present fourteen years and had recurred twice after surgical removal and once after traumatic removal. It was a large pedunculated tumor on the right side of the lower jaw, about the size of a walnut, and looked like an active sarcoma. It interfered with complete occlusion. An enlarged lymph node was present in the submaxillary region on each side. The lesion was removed by surgical diathermy, and two retained dental roots were discovered and removed. Marked dental sepsis was present.

Microscopic examination revealed a chronic inflammatory granuloma composed of fibrous connective tissue and blood vessels. Many plasma cells were scattered throughout, and near the surface were polymorphonuclear leukocytes and lymphocytes.

A roentgenogram showed pronounced notching of the alveolar process, apparently due to pressure absorption resulting from the slowly growing tumor rather than to invasion of the bone.

DIFFERENTIAL DIAGNOSIS

A great variety of neoplasms may occur along the gums. In addition to the entity described above, Thoma listed the following: papilloma, fibroma, fibrosarcoma, myxosarcoma, osteogenic sarcoma, lipoma, fibrolipoma, neuroma, endothelioma, teratoma, lymphosarcoma, adenoma (parotid tumor), carcinoma, hemangioma and lymphangioma. To these one might add granuloma pyogenicum, as well as granulomatous lesions due to syphilis, tuberculosis and fungous infections, such as actinomycosis.

It is of special importance to differentiate epulis granulomatosa from carcinoma, which it may closely resemble and which is one of the more common and more serious lesions affecting the buccal cavity. Carcinoma usually arises from a preexisting patch of leukoplakia, but this fact alone does not serve to differentiate it from epulis granulomatosa, as another patient whom we have recently observed showed several areas of extensive leukoplakia of the buccal mucosa, which extended to the gum and there merged with a hypertrophic spongy papillomatous growth, which on removal revealed a histologic picture consistent with epulis granulomatosa and showed no evidence of epidermal malignancy. Carcinoma is likely to be harder and whiter, owing to the epithelial proliferation. Ulceration may appear in either condition, and both conditions may occur in mouths showing signs of poor hygiene. Biopsy, being the only method of establishing a positive diagnosis, is imperative, but the specimen should be excised by means of the endotherm knife, followed by heavy electrodesiccation to the wound.

TREATMENT

The patient whose case is reported in this paper made a complete recovery after mild treatment with roentgen rays and radium in doses which would have been wholly inadequate for the treatment of cancer. In the cases reported by Thoma and Figi the condition was successfully cleared up by means of the endotherm knife or by cautery. Of paramount importance is the eradication of foci of dental sepsis, retained fragments of roots, sequestrums, etc.

SUMMARY

A case of epulis granulomatosa is presented, and the clinical and histologic features are discussed.

This entity, which is encountered rather infrequently and is discussed inadequately in most textbooks on diseases of the skin and the mouth, is a granulomatous hyperplasia of connective tissue and endothelium, showing chronic inflammation. It is apparently caused by infections of the teeth and gums.

Differential diagnosis from epithelioma and other neoplasms of the gum is important.

Treatment by relatively small doses of roentgen rays or radium or by destruction with the endotherm knife, cautery or electrodesiccation, together with removal of associated septic processes, usually results in complete cure.

The prognosis is good, although inadequate treatment may be followed by recurrence. The possibilities of ultimate malignant degeneration following long-continued trauma and of ulceration of such lesions must be considered.

2007 Wilshire Boulevard.

EPIDERMOPHYTOSIS

REPORT OF CASES IN THREE BROTHERS, ONE OF WHOM SHOWED A HITHERTO UNDESCRIBED CLINICAL TYPE ON THE SCALP

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This report deals with observations on three brothers, all of whom suffered from epidermophytosis and one of whom (case 1) presented a hitherto undescribed clinical type of fungous infection.

REPORT OF CASES

CASE 1.—F. N., aged 16, had a typical eczema marginatum involving the inguinal regions, the adjoining parts of the abdomen and thighs, the lateral side of the right thigh and the left axilla. The toes were erythematous and scaly, particularly in the interdigital folds and on the plantar surface. The process extended to the dorsal surface of the feet, where there were also slightly reddened patches limited by delicate scaly borders. On the central parts of both soles the epithelium was hyperkeratotic, furrowed and markedly scaly.

The scalp (fig. 1), especially in the frontal region, was covered with a diffuse rather adherent layer of scales possibly more grayish yellow than the scales of ordinary pityriasis capitis. There was no loss of hair, and the individual hairs appeared to be normal. Scaling was also present on the face, particularly on the eyebrows, on the ears, on the temples and in the preauricular regions. The skin in general was mildly ichthyotic.

CASE 2.—J. N., aged 19, also had a slightly ichthyotic skin, but the condition was less marked than in his younger brother. He had a typical eczema marginatum of the genito-crural region, perineum, left axilla and umbilical region and an intertriginous eczema between the toes.

CASE 3.—S. N., aged 25, lived away from the family home but had visited there for two weeks when his cutaneous symptoms appeared as an eczema marginatum of the genito-crural region, extending downward somewhat on the medial aspect of the thighs. He showed no evidence of ichthyosis. His brothers had shown symptoms for a few weeks at the time of his visit.

Mycologic Studies.—Scrapings from all the aforementioned regions, including the pityriasic areas of the scalp and face of F. N. (case 1), showed the organism, and a rather straight, branched, partly septate mycelium was present (fig. 2). To our surprise, the filaments were most abundant in the scrapings from the scalp of that patient. Plantings of material from the regions microscopic examinations

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Read before the Norwegian Dermatological Society, Dec. 3, 1936.

From the Department of Dermatology, Rikshospitalet of the University of Oslo, Service of Professor N. Danbolt.

of which gave positive results were made on Sabouraud's maltose-peptone-agar medium. At room temperature growth appeared in from eleven to nineteen days in the tubes containing material from the right foot, left ear and scalp of F. N. No growth appeared after one month in the remaining tubes, which had been placed in an incubator at 37 C. for one week. The colonies started as several yellowish green powdery points in each tube. Transplants were made to similar culture mediums, and after one month the diameter of the colonies was about 2.5 cm. The center of the colonies was raised, showing cerebriform convolutions with a few radial folds extending to the periphery, which was flat (fig. 3). The surface of the center was dry and powdery, while the periphery was covered with a short down which made the borders fringed. The color varied a little

Fig. 1 (case 1).—Diffuse pityriasis from which E. inguinale (Sabouraud) was obtained in culture.

in the different colonies but was mainly brownish yellow in the center, while the periphery was yellowish green. Pleomorphism occurred in from twenty-five to thirty-two days.

The gross morphologic diagnosis of the fungi was Epidermophyton inguinale (Sabouraud). Microscopic examination verified the diagnosis and showed a branched mycelium, partly septate, with terminal and intercalary chlamydospores. The organs of fructification were of one kind, namely, large spindles with rather blunt ends, partly multilocular. The spindles were either attached to the mycelium, some on a short stalk, or isolated. The arrangement in banana-like bunches was infrequent.

COMMENT

Several points are notable in these three cases. It is rare to find three brothers suffering from epidermophytosis of such extent. From an epidemiological point of view it is interesting to note that the brothers used the same wash-stand and towels.

The condition in N. F. and J. N. (cases 1 and 2) was extensive.

Epidermophytosis of the scalp caused by E. inguinale is exceedingly rare. This localization has been previously reported by Weiss, by Arzt and Fuhs and by Matras.[1] These authors described sharply limited spots on the scalp similar to those which were present on the glabrous skin. In searching the literature we did not find that the diffuse pityriasic

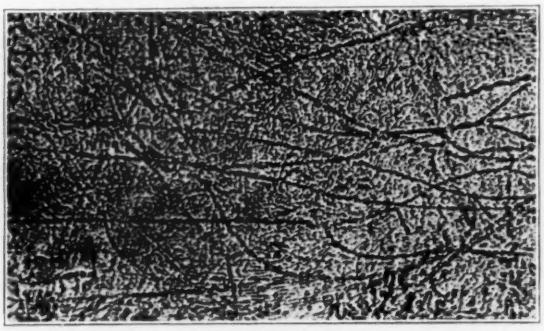

Fig. 2 (case 1).—Microscopic appearance of the fungus.

Fig. 3 (case 1).—Thirty day culture of E inguinale (Sabouraud).

appearance of the scalp and face had been previously described. Concerning the localization on the face it should be mentioned that Karrenberg[2] cultured E. inguinale from a small spot close to one of the corners of the mouth. This spot could not be clinically distinguished from an ordinary pityriasis sicca.

1. Weiss, R.: A Case of Epidermophyton Infection of the Scalp, J. A. M. A. **69**:1059 (Sept. 29) 1917. Arzt, L., and Fuhs, H.: Dermat. Ztschr. **41**:97, 1924. Matras, A.: Dermat. Wchnschr. **87**:1959 (Dec. 29) 1928.

2. Karrenberg, C. L.: Arch. f. Dermat. u. Syph. **154**:605, 1928.

SUMMARY AND CONCLUSIONS

Epidermophytosis in three brothers has been described. Scrapings from all the affected areas in the three patients showed fungi. The hairs were not affected. E. inguinale (Sabouraud) was obtained in culture from material from the right foot, the left ear and the scalp in case 1. No growth of pathogenic fungi appeared in cases 2 and 3. In cases 1 and 2 ichthyosis of a slight degree and multiple and rather extensive areas of epidermophytosis were present. Case 1 is particularly interesting because of the extensive diffuse pityriasis of both the scalp and the face. One might possibly conclude that this pityriasis was caused by E. inguinale. If it was it would be justifiable to suggest a new clinical type, namely, pityriasis epidermophytica diffusa.

REACTIONS TO MAPHARSEN

WITH SPECIAL REFERENCE TO ITS USE IN PATIENTS WHO REACT TO THE ARSPHENAMINES

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Recently Tatum and Cooper [1] reinvestigated a drug (meta-aminoparahydroxyphenylarsine oxide) which they named mapharsen. This drug had originally been studied by Ehrlich and Hata,[2] who expressed the belief that it was too toxic for use in the treatment of human syphilis. Tatum and Cooper, however, found that the "sterilizing therapeutic index" in rabbit syphilis was higher with mapharsen than with neoarsphenamine (1.66 compared with 1.11) and that doses of a given quantity of mapharsen produced results equal to those obtained by from thirty to fifty times as much neoarsphenamine. Raiziss and Severac [3] later disagreed with Tatum and Cooper, stating that the "therapeutic index" given by the latter authors for neoarsphenamine in rabbit syphilis was too low. Raiziss and Severac pointed out that most investigators found neoarsphenamine to have a therapeutic index of about 5. They studied the effects of mapharsen and neoarsphenamine in rabbit syphilis and determined a therapeutic index for mapharsen of 0.92, compared with 5 for neoarsphenamine. They concluded from their work that mapharsen was too toxic for use in human syphilis.

Following this Gruhzit [4] studied the drug in experimentally induced syphilis in rabbits. His results disagreed with those of Raiziss and Severac. He stated that the "curative index" of mapharsen was 4 and that of neoarsphenamine 3.7, and that 1 mg. of mapharsen caused

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From the Department of Dermatology and Syphilology, University of Buffalo, and the Buffalo City Hospital, Service of Dr. Earl D. Osborne.

1. Tatum, A. L., and Cooper, G. A.: Experimental Study of Mapharsen (Meta-Amino Para-Hydroxy Phenyl Arsine Oxide) as Antisyphilitic Agent, J. Pharmacol. & Exper. Therap. **50**:198-215 (Feb.) 1934.

2. Ehrlich, P., and Hata, S.: Die experimentelle Chemotherapie der Spirillosen, Berlin, Julius Springer, 1910.

3. Raiziss, G. W., and Severac, M.: Comparative Chemotherapeutic Studies of "Arsenoxide" (3-Amino-4-Hydroxy-Phenyl-Arsenoxide) and Neoarsphenamine, Am. J. Syph. & Neurol. **19**:473-480 (Oct.) 1935.

4. Gruhzit, O. M.: Mapharsen ("Arsenoxide") in Therapy of Experimental Syphilis and Trypanosomiasis, Arch. Dermat. & Syph. **32**:848-867 (Dec.) 1935.

syphilitic lesions to heal and spirochetes to disappear from open lesions as rapidly as did 10 mg. of neoarsphenamine. He found 3 injections of 1 mg. of mapharsen per kilogram of body weight produced a cure in 80 per cent of syphilitic rabbits. It took 3 doses of 30 mg. of neoarsphenamine to produce the same results.

Foerster and his co-workers [5] first studied the effect of mapharsen in early human syphilis. From their observations in 80 cases they found the dose usually required for therapeutic efficiency to be approximately one-tenth that required with neoarsphenamine.

Kulchar and Barnett [6] in a study of 56 cases of syphilis gave 1,270 injections of mapharsen. They stated that the healing of cutaneous lesions was slightly more rapid; reactions were more common, and reversal of serologic reaction was slower than with neoarsphenamine.

Moore and his associates [7] compared the rates of reversal of the Wassermann reaction with five different arsphenamines in early syphilis. By the use of carefully titrated weekly Wassermann tests they found the average response to mapharsen and that to old arsphenamine were almost identical, while that to neoarsphenamine was slightly less.

Gruhzit and Dixon [8] treated 4,841 patients with 75,589 injections of mapharsen and found the drug to be a potent antisyphilitic agent. Their results compared favorably with those obtained by investigators who employed the other arsphenamines. With continuous treatment consisting of alternating courses of mapharsen and bismuth, negative serologic results were maintained in 100 per cent of cases of seronegative primary syphilis and obtained in 92 per cent of cases of seropositive primary syphilis and 97 per cent of cases of secondary syphilis. Serologic relapse occurred in 14.9 per cent of cases followed for from two months to two years.

Thus the work of these investigators tends to show that from the standpoint of disappearance of spirochetes, healing of local lesions and rate of reversal of the Wassermann reaction, mapharsen is a potent antisyphilitic drug. However, the permanency of results with this drug has not yet, in our opinion, been satisfactorily evaluated.

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5. Foerster, O. H.; McIntosh, R. L.; Wieder, L. M.; Foerster, H. R., and Cooper, G. A.: Mapharsen in Treatment of Syphilis: Preliminary Report, Arch. Dermat. & Syph. **32**:868-892 (Dec.) 1935.

6. Kulchar, G. V., and Barnett, C. W.: Mapharsen in the Treatment of Early Syphilis, Am. J. Syph., Gonor. & Ven. Dis. **20**:482-486 (Sept.) 1936.

7. Moore, J. E.; Hardy, S. M.; Robinson, H. M., and Eagle, H.: The Response of the Quantitatively Titered Wassermann Test in Early Syphilis to Treatment with Five Different Arsenical Drugs, Am. J. Syph., Gonor. & Ven. Dis. **20**:503-514 (Sept.) 1936.

8. Gruhzit, O. M., and Dixon, R. S.: Mapharsen in Mass Treatment of Syphilis in a Clinic for Venereal Diseases, Arch. Dermat. & Syph. **34**:432-454 (Sept.) 1936.

Some data have been accumulated regarding the frequency and severity of untoward reactions among patients treated with mapharsen.

Foerster and his co-workers found that 36 of their 80 patients had no reaction; 15 had one and 9 had two. They stated that these reactions were mild and usually consisted of headache, nausea and diarrhea. However, icterus developed in 4 of the 80, or 5 per cent. In many instances in which a dose of 0.06 Gm. was not well tolerated a dose of from 0.04 to 0.05 Gm. caused no discomfort. They further stated that a dose of 0.06 Gm. is in excess of the amount needed for therapeutic effectiveness.

Kulchar and Barnett claimed that reactions are more common with mapharsen than with neoarsphenamine. They found that nausea, vomiting, diarrhea and abdominal pain occurred in 15.9 per cent of their patients treated with mapharsen, while in only 6.5 per cent of those treated with neoarsphenamine did one or more of these reactions develop. They noted immediate reactions to be less common with mapharsen than with neoarsphenamine (1.1 compared with 2.1 per cent). Dermatitis was less common with mapharsen (0.5 per cent) than with neoarsphenamine (0.7 per cent).

However, Gruhzit and Dixon in their extensive study found a much smaller incidence of reactions among patients treated with mapharsen than did Kulchar and Barnett. They found gastro-intestinal reactions in 6.4 per cent of cases, general systemic reactions in 1.22 per cent, dermatitis in 0.95 per cent and icterus in 0.1 per cent. They reported no cases of hemorrhagic encephalitis, agranulocytic or aplastic anemia, thrombopenia, severe nitritoid crisis or yellow atrophy of the liver. There have been no deaths reported as a result of treatment with mapharsen.

We have been interested in the study of reactions to the arsphenamines and the methods of their prevention. One of us in association with Osborne [9] has shown that in some cases of arsphenamine dermatitis small subtherapeutic doses of the arsphenamines will be tolerated. The Cooperative Clinical Group [10] has demonstrated that relatively small reductions in dosage of the common arsenicals will control arsenical reactions fairly satisfactorily. This led us to believe that mapharsen, because of the relatively low dosage employed, might be an effective drug for use in patients who react to the commonly employed arsphenamines.

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9. Jordon, J. W., and Osborne, E. D.: Observations on Arsphenamine Dermatitis, with Special Reference to Reliability of Patch Test, New York State J. Med. **35**:210-215 (March 1) 1935.

10. Cole, H. N., and others: Cooperative Clinical Studies in the Treatment of Syphilis: Arsenical Reactions, Ven. Dis. Inform. **14**:173-200 (Aug.) 1933.

During the past two years we have employed mapharsen as a routine in the treatment of patients who reacted severely to other drugs. In most instances mapharsen was employed only for patients who had repeated reactions to one or more of the other arsenicals. For many patients reduction in dosage of the original drug and substitution of one of the other common arsenicals had been tried without success. Our group of patients consisted of "persistent reactors."

In our cases are represented all types of syphilis, primary, secondary, asymptomatic and cardiovascular syphilis and neurosyphilis, in both sexes and among all age groups.

Summary of Results

Type of Reaction to Other Drugs Employed Before Mapharsen	Total Number of Patients	Number of Patients Who Tolerated Mapharsen Well	Number of Patients Who Reacted to Mapharsen	Total Number of Injections Given Patients Who Tolerated Mapharsen Well	Total Amount (Gm.) of Drug Given Patients Who Tolerated Mapharsen Well	Average Number of Injections Given Patients Who Tolerated Mapharsen Well	Average Dose (Gm.) of Mapharsen Given Patients Who Tolerated It Well	Reason for Discontinuing Mapharsen Among Patients Who Reacted to the Drug
Gastro-intestinal reaction	64	53	11	578	20.79	11	0.036	Further gastro-intestinal reactions in 9, severe headaches in 1 and jaundice in 1
Nitritoid reaction.....	20	17	3	168	6.33	10	0.038	Gastro-intestinal reactions in 2 and severe headaches in 1
Jaundice.....	18	16	2	161	6.31	10	0.039	Second attack of jaundice in both patients
Cutaneous reaction.....	8	5	3	74	2.37	15	0.033	Urticarial recurrence in 1, recurrence of fixed eruption in 1 and mild recurrence of crustaceous dermatitis in 1
Total.....	110	91	19	981	35.80	10.8	0.036	

NOTE.—The 19 patients who experienced reactions to mapharsen received a total of 43 injections of the drug.

A total of 154 patients who had reacted to arsphenamines were given 1,126 injections of mapharsen. Of these, we were able to follow up 110, who had received 1,024 injections. The reactions represented among our patients have been divided into four groups, namely, gastro-intestinal, nitritoid and cutaneous reactions and post-arsphenamine jaundice.

The accompanying table is a summary of the results of our observations on the effectiveness of mapharsen in controlling the four types of reactions mentioned. By the term "tolerated well" we mean that the patient was able to continue use of the drug in therapeutic dosage with little or no discomfort. By "reacted" we mean either that the previously experienced reaction recurred with sufficient severity to war-

rant discontinuing administration of the drug or that some new reaction occurred which made it advisable to stop the medication.

COMMENT ON RESULTS

Gastro-Intestinal Reactions.—Sixty-four patients who had had repeated severe gastro-intestinal reactions were treated with mapharsen. Of these 64 patients, 53, or 82.8 per cent, tolerated the drug well. Twenty-one of the 53 patients had proved intolerant to more than one of the other arsenicals. The 53 patients received a total of 578 injections of mapharsen, each patient receiving an average of 11 injections of 0.036 Gm., with little or no further discomfort.

It was noted that in the 11 patients who were intolerant to mapharsen the reactions appeared shortly after administration of the drug was begun. They received an average of 3 injections of 0.03 Gm. each before it was necessary to discontinue treatment. In 9 of these patients further gastro-intestinal reactions developed. In 1 of the 11 patients mapharsen was discontinued because of the development of jaundice. In a second patient severe headaches developed.

Nitritoid Reactions.—Twenty patients who had had severe repeated nitritoid reactions from treatment with one or more other arsenicals were given mapharsen. Thirteen of these had experienced nitritoid reactions to either arsphenamine or neoarsphenamine as well as to silver arsphenamine. The twenty patients received a total of 168 injections of mapharsen, and none showed a nitritoid reaction. We found that the drug could be used in full dosage without danger of such a reaction. However, in 3 of the patients a different type of reaction appeared. In two instances, these were of the gastro-intestinal type; in another severe headaches developed. Administration of the drug to these 3 patients was stopped. The patients who tolerated the drug well received an average of 10 injections of 0.038 Gm. each.

Jaundice.—Eighteen patients who had had postarsphenamine jaundice (at varying intervals after recovery) were further treated with mapharsen. Of these, 16, or 88.8 per cent, tolerated the treatment well and received an average of 10 injections of 0.039 Gm. each. In the other 2 jaundice developed in 1 patient after 3 injections of 0.03 Gm. and in the other after 12 injections of 0.04 Gm. Both patients had an uneventful recovery when administration of the drug was stopped.

Cutaneous Reactions.—Eight patients who had had various types of cutaneous reactions to other arsenicals were treated with mapharsen. The following are the types represented and the outcome following further treatment with mapharsen:

1. Two patients who had had mild papular postarsphenamine dermatitis were treated with an average of 17 injections of mapharsen totaling 1.02 Gm., the average dose being 0.03 Gm. The dermatitis did not recur.

2. Two patients in whom urticaria had developed after arsphenamine were treated with mapharsen. In one the urticaria recurred following 1 injection of 0.01 Gm.; in the other no urticaria followed 14 injections of 0.04 Gm. each.

3. After having had a fixed arsphenamine eruption, 1 patient was treated with mapharsen. The eruption recurred following 2 injections of 0.03 Gm. each.

4. One patient who had had a plaquelike arsphenamine dermatitis tolerated 8 injections of mapharsen of 0.03 Gm. each.

5. One patient with generalized pruritus from arsphenamine later tolerated 18 injections of mapharsen of 0.03 Gm. each.

6. In 1 patient who had had a crustaceous arsphenamine dermatitis a mild recurrence appeared after the second injection of mapharsen of 0.01 Gm.

To summarize: Five out of 7 patients who had had minor arsphenamine dermatitis tolerated mapharsen well. One who had had severe crustaceous dermatitis was unable to tolerate the drug.

COMMENT

Our study of 110 patients who had had persistent reactions to the commonly employed arsphenamines indicates that mapharsen is effective in controlling nitritoid reactions, since in none of our 20 patients did a typical nitritoid reaction develop after treatment with mapharsen. In this respect our results agree with those of Gruhzit and Dixon and of Foerster and his co-workers. These authors, employing routine treatment in a large group of patients, observed no typical nitritoid reaction. We found further that many patients who had had severe gastro-intestinal reactions from the arsphenamines would tolerate mapharsen in doses of approximately 0.04 Gm. without further serious discomfort.

We believe that mapharsen, like all the arsphenamines, is a hepatotoxic drug, since in 2 of our 18 cases jaundice recurred when it was administered. In a third instance jaundice resulted when a patient who had had gastro-intestinal reactions to arsphenamine was given mapharsen. This incidence of recurrent jaundice is rather high. Moore [11] stated that of more than 100 patients treated with arsphenamine following

11. Moore, J. E.: The Modern Treatment of Syphilis, Springfield, Ill., Charles C. Thomas, Publisher, 1933.

postarsphenamine jaundice, a second attack developed in only 2. Wile and Sams [12] found no recurrence of jaundice following further arsphenamine therapy. Foerster and his co-workers reported an incidence of jaundice in 4 of 80, or 5 per cent, of cases in which they had used mapharsen. We believe, therefore, that mapharsen is at least as icterogenic as the arsphenamines and should be used with caution in cases of postarsphenamine jaundice.

In the treatment of patients who had had minor cutaneous complications following use of the arsphenamines, mapharsen was generally well tolerated. But in 1 patient who had had a crustaceous arsphenamine dermatitis previously 2 small doses of 0.01 Gm. of mapharsen each produced a mild recurrence of symptoms. It is evident, therefore, that mapharsen cannot be used with impunity after a severe arsphenamine dermatitis, and in view of Gruhzit's findings mapharsen can always be expected to produce a certain percentage of cutaneous reactions.

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12. Wile, U. J., and Sams, W. M.: Study of Jaundice in Syphilis: Its Relation to Therapy, Am. J. M. Sc. **187**:297-315 (March) 1934.

SENSITIZATION OF GUINEA-PIGS TO POISON IVY

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In the attempt to understand epidermal sensitivity (eczema) in man, it is only natural that fundamental studies should have first been carried out with a favorite laboratory animal, the guinea-pig.

A review of the literature reveals that Bloch [1] was the first investigator to succeed in producing eczema (epidermal sensitization) in the guinea-pig. He and his co-workers found that when a small area of the skin was abraded and painted with primula extract, both local and general epidermal sensitivity appeared later.

After Bloch's experiments a number of investigators have reported studies on sensitization of guinea-pigs to paraphenylenediamine, and the studies of Landsteiner and Jacobs [2] stand out, perhaps, as the most illuminating. In the laboratory of the Rockefeller Institute these experimenters found that by repeated intracutaneous inoculation or repeated inunction of guinea-pigs with a number of simple compounds they obtained cutaneous sensitization which was easily reproducible. Positive effects were obtained with 1,2,4-chlorodinitrobenzene, paranitrosodimethylaniline, 1,2,4-trinitrobenzene, trinitrophenol chloride, four different dichlorodinitrobenzenes, paraphenylenediamine and a number of other aromatic compounds. Reactions of cross-sensitization were noted among related substances. Subcutaneous or intravenous, instead of intracutaneous, injections effected only slight sensitization. The authors expressed the belief that immunization by simple substances can be

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1. Bloch, Bruno: The Rôle of Idiosyncrasy and Allergy in Dermatology, Arch. Dermat. & Syph. **19**:175 (Feb) 1929.

2. Landsteiner, Karl, and Jacobs, John: (*a*) Studies on the Sensitization of Animals with Simple Chemical Compounds, J. Exper. Med. **61**:643 (May) 1935; **64**:625 (Oct.) 1936; (*b*) Sensitization of Guinea-Pigs with Methyl Heptine Carbonate, J. A. M. A. **106**:1112 (March 28) 1936.

explained if one may assume a combination of the compounds with the tissue proteins, which is probable in the case of paraphenylenediamine.

The "allergic" nature of poison ivy dermatitis was, interestingly, demonstrated experimentally in man before it was proved in laboratory animals. Spain [3] was able to sensitize children by epidermal contact, the period of incubation varying from twelve hours to seventeen days and the reactions in 65 per cent of the subjects becoming positive to the contact test (whereas previously all had been negative). Straus [4] and Field and Sulzberger [5] have also experimentally produced sensitization to poison ivy in man, but, so far as we can determine, the Simons, Rackemann and Dienes [6] were the first investigators to report success in the sensitization of guinea-pigs to poison ivy. These observers achieved their results by applying a 10 per cent extract of ivy in acetone or ivy ointment to the unbroken, cleanly plucked skin of the animals at various intervals. They later noted a greater intensity of reaction and a shortened time before its appearance when graded contact tests were done in these animals, as compared with the reactions in guinea-pigs used as controls and not previously treated. They expressed the belief that this intensified reaction represents sensitization of the guinea-pig to poison ivy. No cutaneous sensitivity could be produced by intravenous or intraperitoneal injections of the extract, and the Simons and their associates expressed the belief that their experiments support the thesis that sensitivity of man to poison ivy is acquired as a result of previous contact with the plant.

EXPERIMENTAL PROCEDURES

In our studies we found that every guinea-pig subjected to contact tests reacted to an undiluted or slightly diluted extract of ivy in acetone (10 per cent solid matter).[7] The reaction of the skin of these animals to poison ivy, which is characterized by erythema, edema, oozing and crusting, though not the same as the ordinary gross vesicle or bulla which occurs in man, is nevertheless characteristic and consistent in its appearance and hence probably analogous. The varying

3. Spain, W. C.: Studies in Specific Hypersensitiveness: VI. Dermatitis Venenata, J. Immunol. **7**:179 (March) 1922.

4. Straus, H. W.: Artificial Sensitization of Infants to Poison Ivy, J. Allergy **2**:137 (March) 1931; Experimental Study of the Etiology of Dermatitis Venenata, ibid. **5**:566 (Sept.) 1934.

5. Field, Hans, and Sulzberger, Marion B.: Experiments in Poison Ivy Sensitivity, J. Allergy **7**:139 (Jan.) 1936.

6. Simon, Frank A.; Simon, Margaret G.; Rackemann, Francis M., and Dienes, Louis: The Sensitization of Guinea Pigs to Poison Ivy, J. Immunol. **27**: 113 (July) 1934.

7. The concentrated mixture of ivy in acetone and the mixture of almond oil and ivy were furnished by the Lederle Laboratories, Inc.

reactions to graded dilutions of the ivy extract have enabled us to interpret the following experiments:

1. *Specific versus Nonspecific Sensitization of the Skin to Poison Ivy.*—The hair was plucked and the small amount of remaining fur carefully shaved from an area 5 by 10 cm. on the right side of each of twelve medium-sized white guinea-pigs. The following day no local inflammatory signs were present. The bald areas on four of these guinea-pigs were then painted with the undiluted extract of ivy in acetone. Four were painted with a 10 per cent aqueous solution of phenol, and four were kept untreated as controls. Two days later the same areas of the same guinea-pigs were painted again, and a mild dermatitis was noted in the bald areas of the guinea-pigs previously treated with phenol and a moderate dermatitis in those treated with ivy. This time, however, a 20 per cent solution of phenol was used on the guinea-pigs previously painted with this chemical; but it had to be washed off after a short while because all the guinea-pigs so painted went into shock from presumable absorption of the material. A moderate dermatitis was noted two days later in the bald areas of the animals of both of these treated groups.

Four weeks later the guinea-pigs of all three groups were epilated on both sides, and two days later long narrow areas on both the previously treated and the untreated side were painted with graded dilutions with acetone of the original extract of ivy in acetone. The contact tests thus made were with undiluted extract and with dilutions of 1:10, 1:100 and 1:1,000. Results were then observed at the end of five, twenty-four and forty-eight hours.

The local reactions on both the untreated and the previously treated sites were more intense and more rapid in appearance in the guinea-pigs which had previously been painted with the ivy extract than in those in either of the other groups. All the guinea-pigs which had been previously treated with ivy showed reactions to the 1:100 dilution, and one reacted to the 1:1,000 dilution. The previously untreated guinea-pigs and those treated with phenol showed no reactions to solutions weaker than 1:10. The previously untreated controls and the phenol-painted guinea-pigs showed about the same degree of reaction to the ivy extract. The previously treated areas of the sensitized guinea-pigs showed slightly greater reactions to the contact tests than homologous areas of the skin which had not been treated previously.

Sections from the cutaneous sites showing reaction were studied microscopically. The epithelium was slightly thickened and showed slight intracellular and some intercellular edema. There was considerable round cell infiltration in the epithelium. Definite spongiosis was not seen. The superficial cutis showed edema, vascular dilatation and perivascular round cell infiltration. In one section there was a considerable admixture of scale and crust. In the epithelium were large vesicopustules, with only a small amount of edema in the epithelial strands between them and no definite spongiosis. This picture differs from that seen in similarly exposed human skin by its lack of marked intercellular edema, spongiosis and vesiculation. Brunsting [8] stated that he found typical eczematous changes in guinea-pigs that had been sensitized to ragweed. We did not find such changes in the skin of guinea-pigs sensitized to poison ivy.

Results: (1) The work of the Simons, Rackemann and Dienes [6] in demonstrating sensitization of guinea-pigs to poison ivy was confirmed.

8. Brunsting, Louis A., and Bailey, Richard J.: Ragweed (Contact) Dermatitis Produced Experimentally in the Guinea-Pig, J. Allergy **6**:547 (Sept.) 1935.

(2) Irritation of the skin by phenol showed no nonspecific sensitizing effects so far as poison ivy was concerned. (3) Local sensitization of skin previously treated with antigen was found to be greater than that of corresponding untreated sites on the bodies of the same animals. (4) Microscopic sections showed acute inflammation with slight edema and no spongiosis and vesiculation. One section showed large vesicopustules. The reaction of the skin of guinea-pigs differed from that of human beings.

2. Sensitization of the Epidermis by Combined Intracutaneous and Subcutaneous Injections of Extract of Poison Ivy.—One group (I), of four guinea-pigs, received injections, some intracutaneous and some subcutaneous, of from 0.3

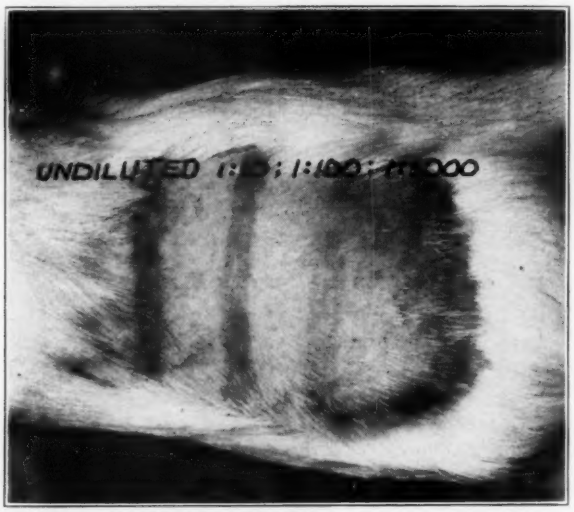

Fig. 1.—Reaction to contact test at twenty-four hours in a guinea-pig previously sensitized to poison ivy.

to 0.4 cc. of the original extract of ivy in acetone three times within twelve days. A small amount of water was added to the extract in the last set of these injections to avoid the severe local irritation which had been noted following the previous injections.

Another group (II), of five guinea-pigs, which previously had been sensitized to horse serum received injections of the extract of ivy in acetone as did group I.

A third group (III), of six guinea-pigs, received injections of an incubated mixture of equal parts of horse serum and the extract of ivy in acetone, each guinea-pig receiving 0.4 cc. intracutaneously and subcutaneously three times in twelve days.

A fourth group (IV), of four guinea-pigs, were kept untreated as controls.

Twenty-three days after the third set of injections, the animals were epilated on one flank, and contact tests were made as in the previous experiment, with the graded dilutions of ivy in acetone.

Results of the contact tests were observed at the end of four, twenty-four and forty-eight hours. The animals in groups I, II and III, which received the injections of the mixtures of ivy and acetone in various combinations, showed more rapid and more intense reactions than the previously untreated control animals of group IV. The animals of group III, which received the mixture of horse serum and extract of ivy, showed more rapid and more intense reactions than did the animals in the first two groups, which received ivy extract alone.

Results: (1) Guinea-pigs were sensitized to poison ivy by combined intracutaneous and subcutaneous injection, the results not differing remarkably from those in the first experiment, in which animals were sensitized by application of the ivy to the surface. (2) Ivy when combined with horse serum (which probably serves as an additional protein haptophore) is more effective in producing sensitization by the means used here than when used alone in the same way. This result is in accord with Landsteiner's [2a] recently expounded haptenic theories of sensitization and Bernstein's [9] studies on anaphylaxis with pollens.

3. *Attempts at Desensitization of Guinea-Pigs to Poison Ivy by Intramuscular Injection of Almond Oil Containing 5 per cent of the Extract of Ivy in Acetone (0.65 per cent Solids).*—For this experiment twenty-two animals which had been used for the previous studies and which had varying but more than intimate degrees of exposure to the extract of ivy (those on which frequent patch tests, painting, injection or various combinations of the three had been performed) were used, in addition to a fresh group of guinea-pigs that had had no previous contact with poison ivy.

For attempted desensitization, eleven of the sensitive guinea-pigs and one previously untreated guinea-pig each received one-third ampule (0.33 cc.) of Lederle's mixture of almond oil and ivy (0.65 per cent solids) intramuscularly three times within thirty-four days.

Since immunity to subsequent attacks of ivy dermatitis in man is supposed to occur within six weeks after the first injection of the almond oil mixture (Coca—personal communication), the twenty-two sensitized animals were given contact tests before the experiment, and all the animals were given contact tests eight and twelve weeks after the initial injections. Graded dilutions with acetone of the extract of ivy in acetone were used for the contact tests as in the first two experiments, and results were observed at intervals of twenty-four and forty-eight hours.

Eleven of the twenty-two previously sensitive animals which received the intramuscular injections of almond oil and ivy did not show less intense or less rapid reactions, as determined by the tests at eight and twelve weeks, than did the eleven other sensitized guinea-pigs, which did not receive the injections of oil. The members of these two groups had shown equally intense reactions in the set of contact tests done before the injections were started.

One guinea-pig that was not previously exposed to ivy, but was given an injection of the mixture of almond oil showed a more rapid and intense reaction to ivy than did any of the guinea-pigs in any of the experiments, except those in which the animals were sensitized by previously painting the skin with the extract of ivy and acetone. (This suggests that this animal was sensitized to the ivy by the intramuscular injections, which is in accord with our results showing that

9. Bernstein, Clarence, Jr.: Studies on Anaphylaxis with Pollen, J. Exper. Med. **61**:149 (Feb.) 1935.

guinea-pigs may be sensitized by combined intracutaneous and subcutaneous injections. This particular finding, though certainly not conclusive, warrants repetition of the specific experiment with a larger number of unsensitized animals.)

Results: (1) Intramuscular injections of almond oil and ivy when used in guinea-pigs in the manner prescribed for use in human beings, do not decrease the sensitization of the animals as determined by contact tests with graded dilutions of the antigen. (Our results in this experiment possibly differ from those reported for human beings, for whom several authors [10] have expressed the belief that the desensitization is of real value in the prevention of further attacks of ivy dermatitis.) (2) Either the phenomena of sensitization to poison ivy are different in guinea-pigs than in human beings, or contact tests as used in our study are inadequate for the evaluation of the prophylaxis afforded by the injections of almond oil.

SUMMARY

The skins of guinea-pigs were sensitized to poison ivy both by application to the surface and by intracutaneous and subcutaneous injection of the antigen. The cutaneous reaction in guinea-pigs was found to differ from that in man, according to the microscopic sections. Intramuscular injections of almond oil and ivy, when used in guinea-pigs in the manner prescribed for use in human beings, do not decrease the sensitization of the animals as determined by contact tests with graded dilutions of the antigen.

10. Blank, J. M., and Coca, A. F.: Study of the Prophylactic Action of an Extract of Poison Ivy in the Control of Rhus Dermatitis, J. Allergy **7**:552 (Sept.) 1936.

A METHOD OF STAINING HAIR AND EPITHELIAL SCALES

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Many dermatologists and laboratory workers will welcome a simple and satisfactory method of staining cutaneous scales and hair for an accurate determination of the presence or absence of fungi. Although a number of methods have been suggested and used by different mycologists, none of these methods has proved to be entirely satisfactory. Sabouraud [1] defatted scales and hair in chloroform, boiled them two to three minutes in formic acid, washed them in distilled water, stained them one minute in Sahli's blue, washed and dehydrated them and mounted them in balsam. Beauverie and Hollande [2] fixed hair and scales in a mixture of alcohol, ether and acetic acid, hydrated them, stained them for ten minutes in polychrome methylene blue, differentiated them in a mixture of glycol and creosote in water, dehydrated them and mounted them in balsam. The chief disadvantage of both of these methods lies in the fact that during the process of dehydration a good deal of the stain is washed out and therefore the preparation is seldom uniformly stained.

In the absence of a simple satisfactory method of staining, many investigators have been led to use such clearing agents as a 5 to 40 per cent solution of potassium hydroxide, lactophenol, chloral hydrate-lactophenol, and chloral hydrate-lactophenol-salicylate. Although such clearing methods permit one to make a microscopic examination of scales leading to a positive diagnosis of fungus infection, nevertheless they are unsatisfactory for a number of reasons. When treated with any of the aforementioned reagents, crystals, globules of fat, red blood cells, cholesterol and the so-called mosaic fungus constitute misleading artefacts, which may at times confuse even an experienced mycologist.

Of the various clearing agents, solution of potassium hydroxide is the one most commonly used, as it is a highly effective clearing agent; however, it is the one most likely to be misleading. Although potassium hydroxide does not destroy mycelia even in a concentration of 40 per

From the Department of Parasitology, American University of Beirut.

1. Sabouraud, R.: Les teignes, Paris, Masson & Cie, 1910, p. 93.

2. Beauverie, J., and Hollande, A. C.: Corpuscles metachromatiques des champignons des teignes: Nouvelle technique de differenciation de ces parasites, Compt. rend. Soc. de biol. **79**:604-607, 1916.

cent, it often results in the formation of crystals which resemble elongated anastomosing hypha-like growths with sporelike particles resembling an actual fungus. Such crystals lack uniformity, are clear, lack content and are irregular in outline. When the preparation is flooded with more solution of potassium hydroxide, these crystals sometimes disappear. It is almost impossible to detect the presence or absence of yeastlike fungi in a potassium hydroxide preparation, as the globules of fat and the red blood cells often assume the contour of blastospores and even simulate budding. Again lack of content and extreme variability in size safeguard one against an erroneous diagnosis.

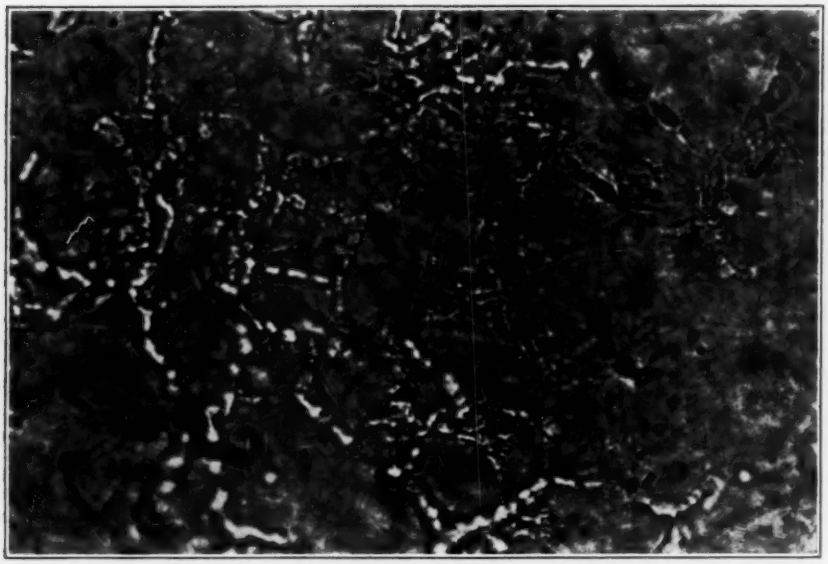

Fig. 1.—So-called mosaic fungus. Note also the presence of rounded yeastlike bodies which are red blood cells and fat globules.

The so-called mosaic fungus (fig. 1) is the most confusing and debated artefact. This is not a fungus at all, or débris of fungus, as it dissolves in ether, absolute alcohol and phenol.

Lactophenol is not a sufficiently strong clarifying agent, and therefore it is seldom used. Chloral hydrate-lactophenol is excellent for the demonstration of mycelia and spores on infected hair and on thin scales from the scalp, but unfortunately a permanent mount cannot be prepared with this clearing agent. Also, it is not suitable for the demonstration of actinomycotic filaments in scales from erythrasma; and it is not suitable for thick scales which swell in chloral lactophenol and do not flatten under the coverslip.

Swartz and Conant [3] described a technic for examining scales which combined clearing in a 5 per cent solution of potassium hydroxide with clearing and staining in lactophenol containing cotton blue (C4B Poirrier). Some mycologists have obtained good results with this method, but it has a distinct disadvantage in that if the washing after the preliminary treatment with a 5 per cent solution of potassium hydroxide has not been sufficient the fungi do not stain regularly, owing to the incompatibility of potassium hydroxide with dyes. The periphery of the scales take the dye, but the center remains unstained. Often the

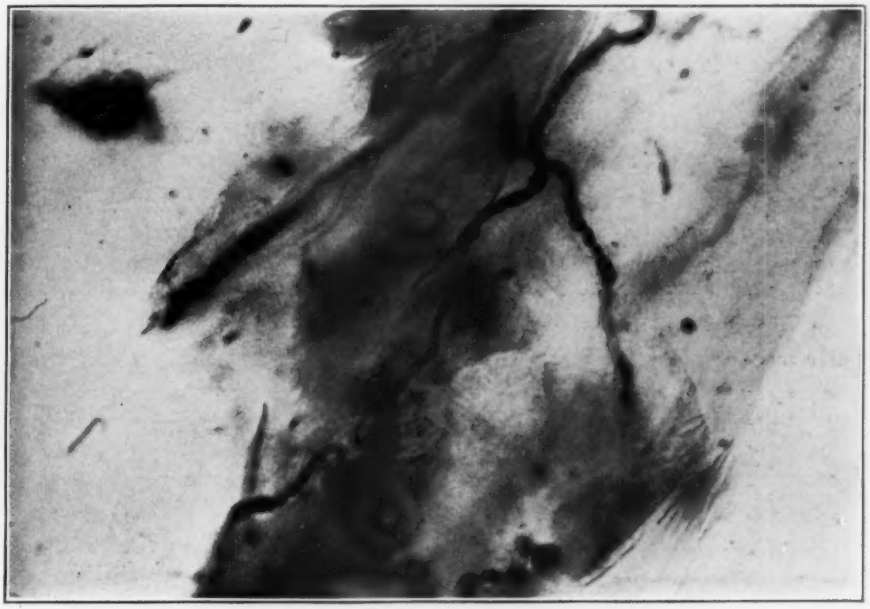

Fig. 2.—Preparation showing deeply stained fungous filaments; × 720.

appearance of crystals in lactophenol preparations makes such preparations useless.

The following method, which is a modification of that used by Guérra, is suitable for staining fungi in thick and thin scales (figs. 2 and 3) and fungi in hair (fig. 4). Epithelial cells, white blood cells and bacteria also stain properly so that there can be no difficulty at all in distinguishing various artefacts from mycotic elements.

TECHNIC OF STAINING SCALES AND HAIR

The scales are cut by means of a safety razor blade or a scalpel into small pieces, from 1 to 2 mm. square, placed on a slide and covered

3. Swartz, J. H., and Conant, N. F.: Direct Microscopic Examination of the Skin, Arch. Dermat. & Syph. **33**:291-305 (Feb.) 1936.

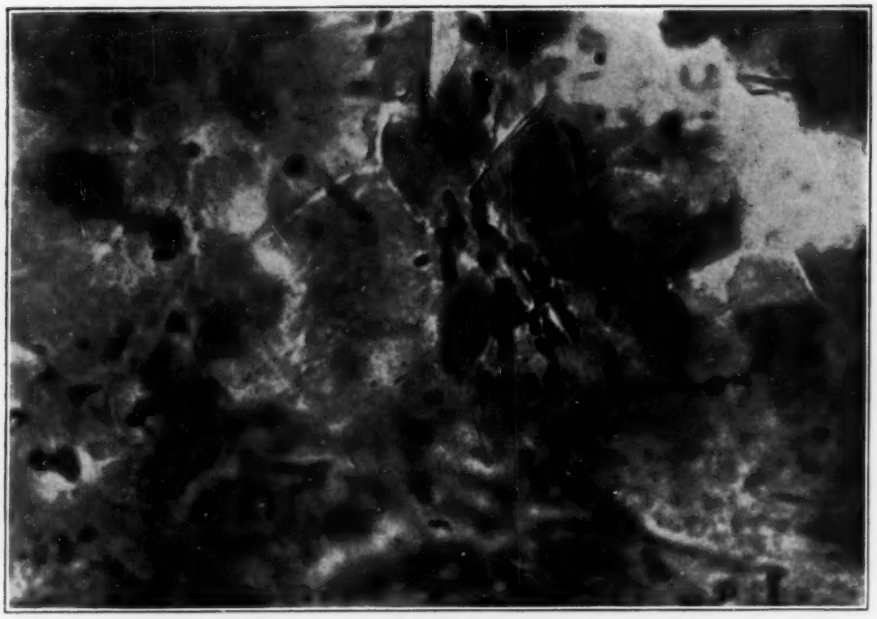

Fig. 3.—Preparation showing heavily stained fungus in which there is a clear differentiation of hyaline sheath and protoplasmic content; × 720.

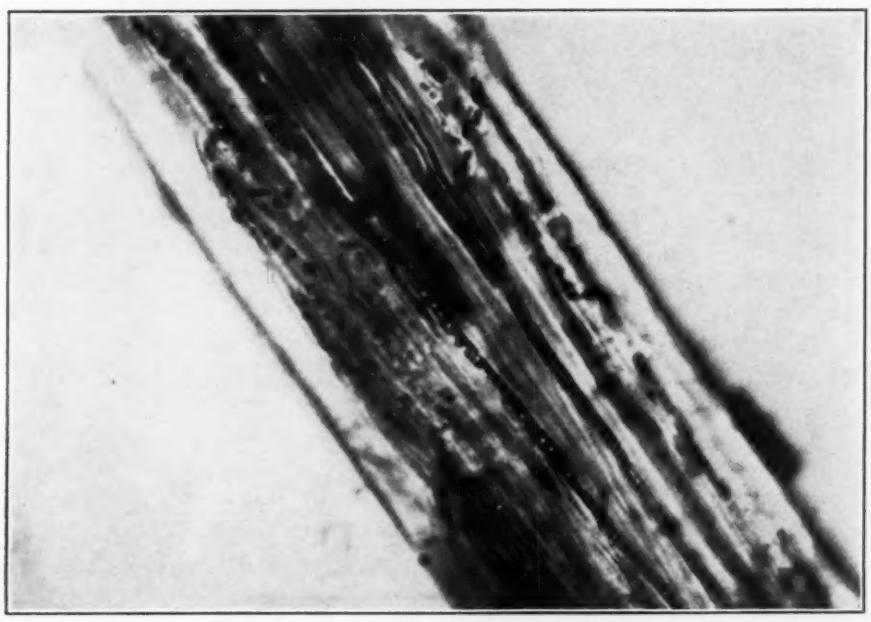

Fig. 4.—Preparation from hair of patient with favus, showing arthrospores of various sizes; × 640.

with a 50 per cent solution of glacial acetic acid in water. The preparation is then dried in an incubator. This process fixes the scales on the slide. The fresher the scales, the better they will adhere to the slide.

The preparation is defatted, cleared and hydrated as follows: It is flooded with ether two or three times, depending on the thickness of the scales, the ether being kept on the slide for from twenty to thirty seconds each time. It is flooded twice with absolute acetone, the acetone being kept on the slide for from thirty to sixty seconds each time. Finally it is flooded consecutively with absolute alcohol and with 95 per cent, 70 per cent and 50 per cent alcohol, the alcohol being kept on for about thirty to sixty seconds each time. The preparation is then stained for from three to five minutes with a solution of toluidine blue prepared according to the formula of Martinotti,[4] which consists of 75 cc. of distilled water, 0.5 Gm. of lithium carbonate and 1 Gm. of toluidine blue.

After the dye is completely dissolved, 20 cc. of glycerin and 5 cc. of 95 per cent alcohol is added.

The slide is washed in water and differentiated with 0.5 per cent acetic acid.

If the scales are still adherent to the slide, dehydration can be best accomplished in jars containing absolute acetone. Usually three changes of acetone are sufficient to accomplish dehydration. The preparation is kept from two to three minutes in each jar of acetone and then passed through xylene and mounted in neutral balsam or preferably in euparol. If during the process of defatting or staining some of the scales have come off the slide, it is preferable to carry on dehydration with acetone by flooding the slide first with absolute acetone from three to four times and then with xylene. If no clouds appear in the xylene, it is a good indication that the preparation has been properly dehydrated. Dehydration in acetone, in contrast to dehydration in graded series of alcohols, does not remove the stain, and a uniformly stained, permanent preparation is obtained. The success of the preparation depends largely on proper differentiation and proper dehydration.

COMMENT

This method may seem lengthy, but it stains beautifully. It clarifies the preparation, dissolves the fat and cholesterol, removes the so-called mosaic fungus, and allows the stain to penetrate into the deeper layers of the scales and stain epithelial cells, pus cells and fungi of all kinds, as well as bacteria. Certain steps in defatting, clearing and hydrating may be omitted at times, depending on the thickness of the scales.

4. Martinotti, L.: Bleu policromo e bleu di toluidina, Ztschr. f. wissensch. Mikr. **27**:24-29, 1910.

THE SUPERFICIAL LYMPHATIC CAPILLARY NETWORK OF THE SKIN

ITS DEMONSTRATION IN VARIOUS CUTANEOUS DISEASES

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Until recently most of the knowledge regarding the lymphatics of the human skin was based on anatomic preparations which at best represented fixed changes in the tissues. These histologic studies showed that the lymphatic vessels, especially the smaller ones, are minute and delicate structures closely associated with but independent of the blood vessels. It was also known that the lymphatic vessels change their size and shape, depending on intrinsic and extrinsic differences in pressure and chemical reactions. The number of active lymphatic capillaries in the living skin probably varies under diverse conditions. Krogh [1] proved that blood capillaries vary in size and number under changing conditions. It is a common experience to find numerous dilated and engorged lymphatic vessels in sections taken from various inflammatory lesions of the skin, such as those of erysipelas and cellulitis. Sections of skin taken from a great variety of cutaneous lesions show similar variations from normal in the size and the contour of lymphatic capillaries.

The lymphatic system is conceived of as closed and relatively independent of the sanguiferous system. It is composed of many large and small vessels, capillaries and lymph glands. There are two networks of lymphatic vessels in the skin: (1) the subpapillary layer, which is a plexus of lymphatic vessels directly beneath the epidermis, and (2) a deeper plexus, closer to the subcutaneous areolar tissue.

The subpapillary layer of lymphatic vessels receives capillaries from the papillae and in turn drains into the deeper plexus. The lymphatic capillaries are endothelium-lined vessels, estimated to vary between 18 and 54 microns in diameter. They have no valves. In addi-

From the Department of Dermatology and Syphilology, Service of Dr. Oscar L. Levin, the Beth Israel Hospital.

1. Krogh, A.: The Anatomy and Physiology of the Capillaries, ed. 2, New Haven, Conn., Yale University Press, 1929.

tion to these capillaries, the skin contains numerous sacculated vessels and larger lymph spaces.

Few studies have been made of the lymphatics of the living human skin. By means of vital stains, Hudack and McMaster [2] succeeded in demonstrating the superficial lymphatic network of the skin in living human and animal subjects. They showed that the lymphatic capillary wall behaved like a semipermeable membrane and that the permeability of the lymphatics of the skin in man was approximately the same as that in mice. The flow of the contents of the lymphatic vessels was seen to be rapid. This was demonstrated by injections into the forearm of dye, which traveled to the axilla in a few minutes. Hudack and McMaster also noted that increased fluid in the subcutaneous tissue compressed the lymphatic capillaries to such an extent as to interfere with their efficiency as drainage channels.

We have attempted to determine whether the superficial lymphatic networks of the skin were altered in various pathologic states of this organ. By means of vital dyes injected into the lymphatics after the technic of Hudack and McMaster we studied one hundred patients selected at random from the dermatologic service of the Beth Israel Hospital.

TECHNIC

Patent blue [3] was selected as the most suitable dye, because it most clearly outlines the lymphatics and because it does not permanently stain the skin. The dye is usually absorbed within forty-eight hours. This was a necessary consideration in overcoming possible objections on the part of the subjects. In the preliminary cleansing of the skin with alcohol, care was taken to avoid friction erythema. The dye was injected by means of a tuberculin syringe with a 27 gage hypodermic needle into the most superficial part of the epidermis. A small wheal, the size of a grape seed, was raised by using from 0.01 to 0.03 cc. of the dye. As no differences were noted in behavior of the dye or structure of the lymphatic network between the skin of the anterior aspect of the thigh and that of the forearm, these two areas were used. The injections were all made by one of us (S. H. S.) in order to insure a uniform technic.

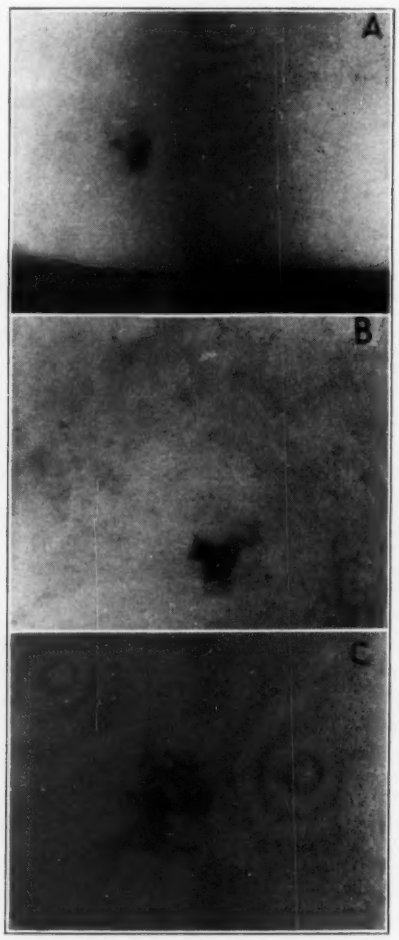
OBSERVATIONS

We observed the following characteristics at each injection: (1) the number of lymphatic capillaries outlined by the dye, (2) the presence

2. Hudack, Stephen, and McMaster, Philip D.: The Permeability of the Wall of the Lymphatic Capillary, J. Exper. Med. **56**:223-238 (Aug.) 1932. McMaster, Philip D., and Hudack, Stephen: Induced Alterations in the Permeability of the Lymphatic Capillary, ibid. **56**:239-253 (Aug.) 1932. Hudack, Stephen S., and McMaster, Philip D.: The Lymphatic Participation in Human Cutaneous Phenomena: A Study of the Minute Lymphatics of the Living Skin, ibid. **57**:751-774 (May) 1933. McMaster, Philip D., and Hudack, Stephen S.: The Participation of Skin Lymphatics in Repair of the Lesions Due to Incisions and Burns, ibid. **60**:479-501 (Oct.) 1934.

3. Patent blue V (prepared by the General Dyestuffs Corporation) in an 11 per cent concentration in distilled water is atonic for blood.

or absence of intercapillary communication, (3) the extent of the longest visualized capillary, (4) the time it took to fill the capillary, (5) the time necessary for the dye to diffuse into the surrounding tissue and (6) the presence or absence of a wheal after the injection.



The three types of lymphatic pattern, as demonstrated in the most superficial part of the skin.

These observations led us to classify the lymphatic patterns of our subjects into three types:

Type A.—In this type few capillaries were outlined; intercapillary communications were not visible, and the size of the capillary buds as outlined was small (fig. *A*).

Type B.—In this type from eight to fifteen capillaries were outlined. There were a few intercapillary communications, with a spread of from 1 to 2 cm. (fig. *B*).

Type C.—In this type from fifteen to fifty capillaries were outlined. There were many intercapillary communications, with a spread of from 2 to 8 cm. (fig. *C*).

TABLE 1.—*A Classification of the Lymphatic Patterns Observed in Various Cutaneous Diseases*

Diagnosis*	Number of Cases	Types		
		A	B	C
Acne	9	4	3	2
Alopecia	2	1	..	1
Dermatophytosis	10	4	3	3
Eczema	11	4	4	3
Epithelioma	2	..	..	1
Erythema multiforme	2	1	1	..
Folliculitis	5	..	3	2
Herpes zoster	2	1	1	..
Intertrigo	2	..	2	..
Lichen planus	3	1	1	1
Pityriasis rosea	4	2	1	1
Pruritus	5	..	1	4
Seborrheic eczema	6	1	1	4
Tuberculosis	6	5	1	..
Urticaria	2	..	2	..
Verruca vulgaris	3	3	..	..
Xeroderma	4	1	1	2

* Single cases of several other dermatoses were studied, and the following types were found: acrodermatitis, C; angioneurotic, B; chronic dermatitis, B; dermatitis herpetiformis, A; dermatitis venenata, C; erythema, C; erythema induratum, A; favus, A; fibroma, B; furunculosis, B; keratosis, C; lupus vulgaris, C; pemphigus, A; psoriasis, A; purpura, C; rosacea, C; senile angioma, B; syringoma, A; toxic eruption, C.

TABLE 2.—*A Classification of Lymphatic Patterns According to Age*

Age, Years	A	B	C	Total
0-10	3	0	0	3
11-20	6	6	4	16
21-30	10	9	3	22
31-40	5	5	7	17
41-50	8	7	7	22
51-60	3	3	3	9
61-70	0	1	7	8
71-80	0	1	2	3
Totals	35	32	33	100

COMMENT AND CONCLUSION

Hudack and McMaster employed vital stains to demonstrate the superficial lymphatic network of the skin in living human and animal subjects.

We utilized a modified technic and injected patent blue V into the superficial portion of the epidermis of one hundred patients displaying various cutaneous conditions.

As a result of these injections it was possible to classify the lymphatic patterns into three types, depending on the number of visualized

capillaries, the intercapillary communications, the size of the dyed area, the time required for filling the capillaries and the presence or absence of a wheal.

It was observed that no disease showed the same type of lymphatic pattern in all cases. Each of the various cutaneous conditions was represented by at least two of the three possible variations in lymphatic pattern. Therefore, it may be stated that no relation was observed between the type of cutaneous lesion and the type of lymphatic pattern.

It was noted, however, that the looser the skin, the greater the lymphatic spread and the more clearly outlined the lymphatics. This held true in almost every case. Since the skin usually becomes looser with increasing age, the findings listed in table 2 become significant. In general, it may be stated that the lymphatic spread increases as the age of the patient advances. Since this increase is associated with the looseness of the subcutaneous areolar and elastic tissue, it seems logical to assume that the lymphatic pattern, as observed during the test, is dependent on the firmness or density of the subcutaneous tissue. We may also assume that our studies have shown the average type of lymphatic structure in the average skin. Finally, it may be said that there is no typical lymphatic picture associated with any specific cutaneous disease.

2 East Fifty-Fourth Street.

SENSE OF SMELL OF PATIENTS WITH NEUROSYPHILIS, ESPECIALLY OF THOSE WITH DEMENTIA PARALYTICA

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Since the discovery of the organism of syphilis by Schaudinn and Hoffmann in 1905, a vast amount of literature has accumulated on pathologic changes in the nerves in syphilis, yet there seems to be but scant reference to syphilis of the olfactory system. Just why this phase of syphilology has been insufficiently studied is difficult to explain, especially when one recalls that the gyrus rectus and the gyrus orbitalis of the frontal portion of the brain are the sites most frequently invaded by the organism.[1]

It is interesting that the sense of smell is frequently not tested during a neurologic examination. It may be that because of the large surface of the brain to be examined (this surface was calculated by Pulcher [2] to be 2,200 sq. cm.) the olfactory system is often examined only macroscopically. Regarding microscopic examination, F. Jahnel stated ". . . in careful examinations for spirochaetes in the brain only one-millionth of the brain is as a rule investigated." [3]

It was therefore considered worth while to attempt to determine how frequently the olfactory system of patients with neurosyphilis is damaged. For this purpose a group of patients were selected and tested by Elsberg's method of olfactometry.[4] One should bear in mind, however, that it is possible for extreme damage due to syphilis to occur bilaterally in the olfactory region without change in the function.

From the Northampton State Hospital.

1. Wertham, Frederic, and Wertham, Florence: The Brain as an Organ, New York, The Macmillan Company, 1934, p. 450.

2. Pulcher, cited by Wertham and Wertham,[1] p. 11.

3. Jahnel, quoted by Wertham,[1] p. 11.

4. Elsberg, Charles A., and Levy, Irwin: A New and Simple Method of Quantitative Olfactometry, Bull. Neurol. Inst. New York **4**:5-19 (March) 1935. Elsberg, Charles A.; Brewer, Earl D., and Levy, Irwin: The Odorous Substances to Be Used for Tests of the Olfactory Sense, ibid. **4**:286-293 (Oct.) 1935. Elsberg, Charles A.: Some Facts Regarding the Psychophysiology of the Olfactory Sense, ibid. **4**:496-500 (Dec.) 1935; The Value of Quantitative Olfactory Tests for the Localization of Supratentorial Tumors of the Brain: A Preliminary Report, ibid. **4**:511-522 (Dec.) 1935.

Henschen[5] concluded that the olfactory regions are so completely innervated bilaterally that unilateral lesions only exceptionally cause a change in function. According to this investigator, if the uncus of one side is preserved, there is no permanent loss of the sense of smell even though other parts are affected. When the uncus is destroyed or compressed, disturbances may occur, but they soon disappear. A unilateral destruction of the gyrus hippocampi does not cause a disturbance of smell, at least if a certain time has elapsed between the occurrence of the lesion and the examination. A destruction of one side of the cornu ammonis need not be accompanied by disturbances of the sense of smell. Even complete destruction of one side of the uncus, gyrus hippocampi and cornu ammonis does not necessarily produce any disturbance of the sense of smell.

Another interesting fact in connection with the seeming invulnerability of the olfactory tract is that in acute anterior poliomyelitis the filtrable virus does not always pass through or affect the olfactory nerve or bulb. Recent experiments on Macacus rhesus monkeys by intracerebral, subcutaneous, intra-ocular and intrasciatic inoculations of a suspension of virus (M. V. strain) failed to produce lesions in the olfactory bulbs.[6] Before going further one should remember that although the olfactory nerve is sensory it is in reality not a true nerve, as it arises from an outpouching of the primitive cerebral vesicles and remains, therefore, a part of the brain.[7]

RESULTS OF OLFACTORY TESTS

Seventy-five neurosyphilitic patients were given the Elsberg olfactory tests. Sixteen were females and fifty-nine were males. Their ages ranged from 16 to 62. Fifty-two of the group had meningoencephalitis; eight had tabes dorsalis; six had latent syphilis and the remaining nine suffered from tardive congenital syphilis, syphilitic epilepsy, early neurosyphilis, late meningovascular neurosyphilis, the tabetic form of dementia paralytica and primary atrophy of the optic nerve.

The blast injection method was used, with coffee and citral as the test substances. The tests were made on both sides of the nose at room temperature. One patient with dementia paralytica and syphilitic

5. Henschen, S. E.: Ueber die Geruchs- und Geschmackezentren, Monatschr. f. Psychiat. u. Neurol. **45**:121-156, 1919.

6. Sabin, Albert B., and Olitsky, Peter K.: The Olfactory Bulbs in Experimental Poliomyelitis: Their Pathological Condition as an Indicator of the Portal of Entry of the Virus, J. A. M. A. **108**:21-24 (Jan. 2) 1937.

7. Grinker, Roy A.: Neurology, Springfield, Ill., Charles C. Thomas, Publisher, 1934, p. 312.

ozena had a normal sense of smell. Another patient, who had an unusual colloidal gold curve, 5555555555, complained that he "had a cold" yet showed good results of the tests.

A 50 cc. glass syringe was used in making these tests. Ground coffee was placed in one glass jar and citral in another. The jars were stoppered as Elsberg has described. A measured amount of air was forced into the jars with the syringe, and the odorous substance passed into the glass rhinal tip when the valve was released. Some of the persons tested could identify the odor when only 2.5 cc. of the odorous substance was blasted into their nostril. Most of them required 5 or 10 cc. One could not identify the odor even when he sniffed at the open jar but identified it when 30 cc. of the odorous substance was blasted into each nostril. As for fatigue, that occurs in the sense of smell just as it does in muscles, and the function of olfaction cannot be employed until the fatigue has disappeared.

*Results of Tests**

Number of Patients Tested	Results of Sniffing	Minimum Identifiable Odor, Cc.		Duration of Fatigue on Both Sides, Minutes
		Coffee	Citral	
1	None	30-30	30-30	9
4	Doubtful	15-15	15-15	2
10	Normal	5-15	5- 8	1-3
60	Normal	5-10	5- 2.5	1-3

* Five normal persons were tested, for the purpose of comparison with the neurosyphilitic patients. The minimum identifiable odor response to coffee was obtained on both sides with an amount averaging 8 cc., whereas for the response to citral the amount was a trifle lower, 7 cc. The duration of fatigue approximated two minutes for both test substances.

It is well known that there is a variance in persons as to the acuity of their sense of smell. Elsberg made the interesting observation that persons with a high degree of intelligence often showed a lack of ability to name familiar odors. Age too often brings about changes in olfaction. Probably there occurs a diminution of olfactory acuity, along with the dimming of the other senses, with advancing age.[8] However, the group of persons tested did not always readily identify the odor. The odor of coffe was variously described as a smell, ether, something, pepper, a light odor, faint, snuff, a sulfur odor, burnt paper, some kind of odor, almond and chewing gum before being eventually identified.

Of the seventy-five patients who were tested, only one had anosmia and could not identify the odor even when sniffing the test substances. Four other patients had an impairment of the sense of smell and had

8. Laird, Donald A.: What Can You Do with Your Nose? Scient. Monthly **41**:126-130 (Aug.) 1935.

difficulty in naming the test substances when sniffing them. A careful examination of the nasal passages of these five patients did not reveal any disease or abnormality.

If one may draw conclusions from observations on seventy-five neurosyphilitic patients who were given the Elsberg smell tests, it is perhaps safe to deduce that the olfactory system is seldom damaged by syphilis and that, if the "all pervasive" Spirochaeta pallida does invade the olfactory tract, it rarely produces anosmia. This is interesting when it is recalled that the gyrus rectus and the gyrus orbitalis of the frontal portion of the brain are the sites most frequently affected by the invading organism.

CUTANEOUS LEPROSY

PRESUMABLE CURE BY SURGICAL REMOVAL OF A LESION

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REPORT OF A CASE

In January 1933 a French priest aged 61, who was officiating in his clerical capacity at the settlement in Hawaii for the care of lepers (Kalaupapa), requested consultation for a cutaneous eruption. This consisted of three closely set dusky red infiltrated lesions on his brow, centrally placed and close to the line that would have been his hair line had he not been bald. The patient stated that he had noticed the lesions for the first time several weeks previously, since which time they had persisted and grown larger. They were regarded as small hard papules when first noticed. Two of the lesions were acuminately nodular, with bases about 1 cm. in diameter. The third was also an elevated lesion but had a flat top and measured about 2 cm. across the base. The infiltration was firm and myxedematous, and the lesions appeared to be coalescing. There was no scaling dysesthesia or other significant change and no history of pain or itching. Microscopic examination of one of the lesions revealed a few acid-fast bacteria resembling Mycobacterium leprae.

A searching physical examination and microscopic examination of scrapings from the nasal mucous membranes failed to disclose other manifestations of leprosy, except for a slight droop of one angle of the mouth. The latter was difficult to evaluate because the patient had a heavy beard. There were no clinical evidences of active tuberculosis or syphilis, and the Wassermann test was negative.

The patient was referred to Dr. Grover A. Batten, a surgeon, who excised the affected area. An incision was made about 1 cm. beyond the infiltration, as determined by palpation, and was carried to the scalp. The skin and subcutaneous tissues were removed *en masse*.

Portions of the excised tissue were macerated by grinding and examined microscopically. Acid-fast bacteria were found in clumps. Several cultures on mediums favorable to the growth of tubercle bacilli were attempted, but no growth appeared after incubation for six weeks. Guinea-pigs were inoculated with the material subcutaneously and intraperitoneally, but they showed no evidence of tuberculosis by macroscopic or microscopic examination at necropsy twelve and fourteen weeks later. Histologic examination of a portion of the tissue revealed changes characteristic of leprosy and exhibited a granuloma extending into the lumen of a blood vessel.

A diagnosis of leprosy was made and concurred in by a clinician of long experience with the dermatologic lesions of the disease.

Published with the approval of the Surgeon General, United States Public Health Service, but without his responsibility for the subject-matter.

Though the patient was well informed, he had been notoriously careless in his personal contacts with lepers, to whom he had ministered in the settlement for approximately eight years, though his duties did not warrant or necessitate the close contact practiced. He was very negligent in cleansing his hands and fingernails and habitually rubbed the tips of his fingers on the central portion of his brow when thinking or reading.

He had lived in Europe throughout his life until he started his trip to Hawaii. While en route he had stopped for several months at one of the South Sea Islands in which leprosy is prevalent, but stated that he knew of no personal contact with lepers during his sojourn.

Since the lesion was excised he has not exhibited any further manifestations of leprosy, and since the postoperative period is now more than four years, it would appear that he may have been cured.

COMMENT

Convalescence from leprosy after removal of the only cutaneous lesion observed has been reported by others. McCoy and his associates [1] reported such a case in a child in 1916, and through a personal communication I have learned that that patient has remained free from further lesions. It has been the belief of others that the course of leprosy is beneficially influenced by the destruction of lesions in the skin by the application of escharotics or by the intradermal injection of a medicament, such as chaulmoogra oil, which stimulates inflammatory reactions.

Entrance of the bacterium through the skin has been considered to be one route of invasion, but whether the organism usually induces a recognizable response in the tissues at the point of invasion has not been determined. It is well established that granulomatous changes frequently develop in animals of several species at the point of intradermal or subcutaneous introduction of large doses of material containing Mycobacterium leprae. However, the disease does not progress in them. Such self-inoculation of the patient with small doses may have taken place in this instance, and likewise the lesion might have healed spontaneously, as more advanced lesions do frequently.

While it is believed that invasion may be through the skin, there is evidence to support the hypothesis that the entrance is usually through the nose and throat and that the dermatologic lesions are later developments, the sites of election of which are influenced by circulatory phenomena produced by any one of numerous extraneous factors, such as trauma caused by pressure. Such an event may have occurred in this case.

The questions of relative immunity, source of infection and even permanency of cure in this case are of course speculative.

1. McCoy, G. W.; Hollmann, H. T., and others: Studies upon Leprosy, Bulletin 75, United States Treasury Department, Public Health Service, 1916.

DERMATITIS OF BUTTOCKS DUE TO SALIGENIN

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The treatment of syphilis is not infrequently complicated by reactions of intolerance to the medicament employed. Untoward symptoms may first appear on the skin in the form of pruritus, urticaria or dermatitis of various forms. The interruption of treatment in the face of such symptoms is a proper precaution, but it may be a serious matter for the patient, especially if the disease is acute or disseminated or if there is active involvement of the heart or central nervous system which calls for intensive treatment.

The patient who is being treated for syphilis may show signs on the skin apart from reactions of sensitivity of this type. There may be recurrence of a cutaneous syphilid, even in the face of intensive treatment; an intercurrent eruption, such as pityriasis rosea or psoriasis, may appear, or there may be symptoms of intolerance to a drug which is used incidentally, such as quinine, acetylsalicylic acid or phenolphthalein. In case of doubt it is wise to suspend all medication until the question of intolerance, to the antisyphilitic remedies at least, can be ruled out. In this respect, the arsphenamines are the chief offenders, whereas preparations of mercury or of bismuth are rarely involved. With the influx of new remedies that are constantly being tried in the treatment of syphilis, one may expect to see unusual reactions.

The present report deals with a case [1] of neurosyphilis in which in the early phases of treatment there was manifest a peculiar erythematous and vesicular eruption of the buttocks that was traced to sensitivity to a new type of local anesthetic, saligenin (salicyl alcohol). This had been incorporated in the solution containing bismuth for intramuscular use. When it was found that the reaction was not due to bismuth, as was first suspected, intensive antisyphilitic treatment was resumed without subsequent evidence of reaction.

From the Section on Dermatology and Syphilology, the Mayo Clinic.

1. The case was presented at the meeting of the Mississippi Valley Dermatologic Society in Rochester, Minn., Sept. 13, 1936 (Arch. Dermat. & Syph. **35**:982 [May] 1937).

REPORT OF A CASE

A merchant aged 48 first came to the clinic on March 16, 1936. He complained of slowly progressing deafness. About twenty-four years previously there had been a penile lesion and a positive reaction of the blood for syphilis. Mercurial inunctions had been given. About four years prior to his admission the patient had been given a few intravenous injections of an unknown drug, presumably neoarsphenamine, as treatment for syphilis.

Physical examination at the clinic revealed obesity, chronically infected tonsils and infection of several teeth, but the most significant observation was active neurosyphilis of the meningovascular type. Serologic tests of the blood revealed that the Wassermann reaction was negative, but the Kline, the Hinton and the Kahn reaction were positive. Examination of the spinal fluid on March 18, 1936, gave the following results: The Kline reaction was 4 plus; the Wassermann reaction was positive (43 — —); the Nonne reaction was positive; the cell count was 19; the protein content was 45 mg. per cubic millimeter, and the colloidal benzoin curve was 000003332110000. Special neurologic examination revealed a slight irregularity in the shape of the pupils and the fact that the right pupil was larger than the left; nerve deafness was present on both sides but there was more on the left than on the right, and there was a slight decrease in the vibratory sense and in the perception of pressure in the right lower extremity.

Treatment was begun by means of the intravenous injection of old arsphenamine, the intramuscular injection of iodobismitol with saligenin [2] and the use of iodides by mouth. During the first week of treatment we noticed a few urticarial plaques about the buttocks in the regions overlying the sites of the intramuscular injections. Treatments were continued cautiously, and a total of seven injections of 2 cc. of iodobismitol with saligenin were given intramuscularly. The earliest urticarial reactions subsided, but new ones appeared which were larger and intensely pruritic. There was some induration of the plaques, and localized edema and vesiculation were noted.

Patch tests to medicated alcohol, which had been used for cleaning the buttock, and to the stock solution containing the iodobismitol were made. At the site of the application of the latter there was a strongly positive vesicular reaction, which appeared in less than twenty-four hours. Further tests were made, the various ingredients of iodobismitol with saligenin being used separately, and a positive vesicular reaction was obtained to the solution of saligenin alone.

On one occasion, in January 1937, as a special test, 1 cc. of the stock solution of iodobismitol with saligenin was injected intramuscularly deep into the buttock without soiling the skin. Within from four to six hours after this injection the skin lying immediately over the site of the puncture began to itch and became red and edematous. The zone of redness increased to a diameter of roughly 12 cm. during the next twenty-four hours, and a cluster of vesicles became evident in the center of the patch, where there was most edema. The inflammatory reaction reached its maximum at the end of the second day and then subsided gradually, without leaving evidence of any residuum. There was no evidence of a systemic reaction.

Further treatment for syphilis was carried out by administration of arsphenamine, inunctions of mercury and injection of various preparations of bismuth, including plain iodobismitol (sodium iodobismuthite). There was no evidence of a subsequent reaction.

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2. The preparation contains 6 per cent sodium iodobismuthite, 12 per cent sodium iodide, and 4 per cent saligenin (salicyl alcohol) in propylene glycol.

COMMENT

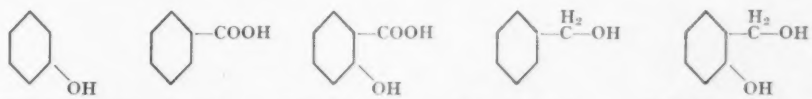
This case is reported as a unique example of epidermal sensitivity to the local anesthetic saligenin (salicyl alcohol), which material reached the skin from the intramuscular depot in the buttock, where it had been injected with iodobismitol in the course of treatment for syphilis.

Hirschfelder and his associates [3] found saligenin a relatively nontoxic and nonirritating local anesthetic and stated that its anesthetic action is more prolonged than that induced by procaine hydrochloride.

Saligenin is orthohydroxybenzyl alcohol, or salicyl alcohol, C_6H_4OH CH_2OH. It occurs as white monoclinic plates. It is partially soluble in water, soluble in chloroform and in the fixed and volatile oils and freely soluble in alcohol and ether. The aqueous solution is neutral to litmus paper. It melts at between 86 and 87 C.

Saligenin was added to the preparation of iodobismitol (sodium iodobismuthite) by the manufacturers early in 1936, in order to overcome the irritating symptoms of burning and pain at the time of injection of the plain iodobismitol.[4] In our previous experience with many hundreds of injections of the plain iodobismitol, we had encountered no evidence of peculiar cutaneous reactivity of any sort.

Saligenin is an aromatic compound containing a benzene ring, and is closely allied to benzyl alcohol, salicylic acid, benzoic acid and phenol, as the following structural formulas show:



Phenol — Benzoic acid — Salicylic acid — Benzyl alcohol — Salicyl alcohol (saligenin)

Patch tests were made with these chemicals in the following dilutions: phenol 0.1 per cent, benzoic acid 0.4 per cent, salicylic acid 1 per cent and benzyl alcohol 1 per cent. None of these tests produced the slightest sign of erythema or vesiculation. This is evidence that there was a specific sensitivity to saligenin and not to its most closely allied chemical neighbors.

Patch tests were also made with the following local anesthetics: pontocain, cocaine, diothane hydrochloride, ethyl aminobenzoate, nupercaine, metycaine, butyn, procaine hydrochloride and chlorobutanol. All gave negative reactions.

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3. Hirschfelder, A. D.; Lundholm, A., and Norrgard, H.: The Local Anesthetic Action of Saligenin and Other Phenyl Carbinols, J. Pharmacol. & Exper. Therap. **15**:237 (May); 261-270 (June) 1920.

4. Hanzlik, P. J.; Barnett, C. W., and Richardson, A. P.: Modified Composition of Iodobismitol, Arch. Dermat. & Syph. **32**:284-287 (Aug.) 1935. Newcomer, H. S.: Personal communication to the authors.

SUMMARY

A patient under treatment for neurosyphilis gave evidence of contact dermatitis of the buttocks, which was found to be a reaction of sensitivity to saligenin (salicyl alcohol), a local anesthetic incorporated in the stock solution of iodobismitol (sodium iodobismuthite). The reaction to saligenin was determined by patch tests to be specific for this material when comparison was made with allied aromatic benzene compounds and other common local anesthetic agents.

This is the first example of contact sensitivity to saligenin that has been reported. After the elimination of this material, further treatment for syphilis proceeded uneventfully and without evidence of reaction.

LACQUERED HAIRPINS HOLDING PSYCHE KNOT PROBABLE CAUSE OF LICHENIFIED ECZEMA OF SCALP

REPORT OF A CASE

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A form of chronic lichenified eczema which corresponds practically in every detail with the classic description of neurodermatitis of Brocq is commonly seen in the occipital area of the scalp in middle-aged women. Signs of seborrheic eczema are usually absent. The circumscription of the lesion, the total lack of exudation throughout its entire course and the invariable absence of eczematoid lesions elsewhere tempt one to identify the process as chronic lichenified eczema resembling neurodermatitis.

The study of such a case of chronic lichenified eczema of the scalp simulating neurodermatitis may serve to show the part probably played in its origin by external local irritants.

REPORT OF CASE

Miss E. M., a middle-aged graduate nurse, in good general health, first consulted me on May 25, 1936, for an intensely itching eruption of the scalp of two years' duration. The condition had been unremitting and was getting worse. Most of the trouble was in the occipital area, but there were also "itchy spots" on the sides of the scalp. The center of the occipital portion of the scalp was occupied by a patch three-fourths the size of the palm, with a sharp, irregularly rounded margin, infiltrated and elevated about 5 mm. above the surrounding skin. The patch was composed of a dry dull reddish inflammatory process covered with diffuse, grayish hyperkeratotic excrescences. At the border the dull red of the basic inflammatory process was slightly exposed beyond this overlying hyperkeratosis. By scraping with the nail some of the horny material was removed, and the underlying process was revealed to be infiltrated and boggy. The patch consisted of accentuated, quadrilateral reddish markings with fine grayish criss-cross lines suggestive of neurodermatitis. In the center of the patch there was some loss of hair. In the parietal portion of the scalp on each side just back of the ear there were three or four sharply defined nickel-sized areas composed of shiny flesh-colored and pinkish papules varying in size from that of a pinhead to that of a split pea. One fourth of an erythema dose of roentgen radiation was given and an antipruritic ointment prescribed. One week later a similar dose of roentgen radiation was given. The patient was cautioned frequently against scratching. Under treatment with various antipruritic ointments and lotions the occipital patch lost its hyperkeratotic appearance, and the bogginess diminished

considerably in two months. However, the patient from time to time complained of itching in new spots adjacent to this patch and also in the parietal regions. By the middle of October the area on the occiput had dwindled to a superficial reddish patch, composed of finely accentuated markings of the skin, with hardly any edema. However, in spite of this objective improvement, the patient still suffered occasional annoying attacks of itching in all the original sites.

Earlier in the course of observation it was felt that the hairpins she used were responsible to some extent, at least mechanically, for the irritation, because the positions they occupied in her hair corresponded exactly with the sites of the lesions. The patient wore her hair in such a manner that the large mass of it was rolled into a psyche knot, which rested on the lesion in the occiput. This knot was supported with from twenty-five to thirty-five hairpins, many of which impinged directly on the inflamed area. The only other places in which hairpins were worn were the parietal regions directly over the sites of the small lesions.

Patch tests were done to determine, if possible, whether induced hypersensitivity to the lacquer on the hairpins was a causative factor. A piece of black hairpin of the type which the patient always used was applied under a patch of moist blotting paper (1 cm. square) to the upper part of the back for thirty-six hours. This test gave negative results. In order to obtain more intimate contact of the test material with the skin, lacquer was scraped with the blade of a knife from the steel frames of several hairpins. A small bit of this powdered material was applied under a piece of moist blotting paper as a patch on the upper part of the back. After twenty-four hours there appeared in this area an intensely itching faint pinkish patch about the size of a dime. The adjacent skin, which had been covered with adhesive plaster to insure retention of the test material, showed no change in color and did not itch. A similar patch test made a week later showed after seventy-two hours an area of redness with slight edema, which extended a short distance beyond the border of the blotting paper. Within the area of redness a few pinpoint follicular papules were seen. In this area there was intense itching. A week after the patch was removed the patient still showed faint signs of the reaction and some itching. Again there had been no reaction from adhesive plaster. In order to rule out the possibility of sensitization to nickel, which might have been present in the steel frame of the hairpin, a pin was scraped free of the lacquer on its surface and the steel frame was applied as a patch. At the same time a nickel was applied as a patch to another area on the back. There was no reaction after forty-eight hours to either the hairpin or the nickel.

The patient was instructed to substitute bone hairpins for the steel ones. Within one week after beginning to use the former, the patient was practically free from itching, and the lesions had almost completely faded. When seen still later she felt that she was cured. At this point she returned to the use of the steel hairpins, and after one week she noted some return of itching.

The glossy black material which coats the steel frame of the ordinary hairpin is, as nearly as can be determined, a cellulose lacquer of one of two possible compositions. The first formula consists of cellulose acetate, glycol phthalate and a solvent, whereas the second has additional glycomonomethylether. It seems fair to assume that the most likely source of irritation would reside in the solvent, which consists of ethylene dichloride, denatured alcohol, glycomonomethylether and methyl cellosolve acetate. After the hairpins have been worn for varying periods the lacquer is worn away. In the case described here, when the hairpins were first inspected it was found that at least half of them showed considerable warping along the prongs, with resultant exposure of the steel frame. It is probable,

therefore, that loose particles of lacquer are frequently deposited on the scalp and occasionally exercise a provoking effect chemically in addition to the mechanical irritation of the hairpins themselves.

For purposes of control two other patients were tested with the powdered lacquer; the results were negative.

SUMMARY

I have never seen chronic lichenified eczema simulating neurodermatitis on the occiput of a man. The wearing of the uncropped hair in a psyche knot over the occipital portion of the scalp supported and fixed by a number of lacquered steel hairpins seems to be a physical and mechanical irritant which may be a primary, provoking, or at least a secondary, aggravating, factor in chronic lichenified eczema of the scalp. The inflammatory response may, in predisposed persons, be due to hypersensitivity to the lacquer of the hairpins, as appears to be true of the patient whose case is recorded here. The increased temperature and perspiration, the pressure of the knot of hair over the occipital portion of the scalp and the sticking qualities of the prongs of the hairpins probably all play offending rôles. The patient reacted positively to a patch test with the powdered scrapings of lacquer from steel hairpins. Tests of two other patients used as controls gave negative results. Substitution of bone hairpins gave complete relief from symptoms.

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RINGWORM OF THE SCALP

V. MECHANISM OF CURE OF INFECTIONS CAUSED BY MICROSPORON LANOSUM

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In previous reports [1] attention has been drawn to the tendency to spontaneous cure and to the invariably favorable response to the local application of fungicides in patients with ringworm of the scalp caused by Microsporon lanosum. It was shown that epilation by means of roentgen rays or thallium acetate is unnecessary in the treatment of such patients. It has been of interest to note the uniformly good response to treatment when ointments of weak as well as of concentrated strength were employed, and also to observe the regularity of the response to a large number of different applications. When no further infection can be demonstrated in a patch, almost complete or complete epilation has occurred. These observations have led us to be skeptical regarding the specific action of drugs in the treatment of this type of tinea capitis. In order to determine whether cure in these patients could be explained on a mechanical basis alone, we undertook the following experiment.

METHOD

Children with ringworm of the scalp were selected in whom the infecting organism was M. lanosum and who had patches of typical active involvement. There were no other children in the families of these patients, and since the parents were cooperative and of average intelligence no fear was felt that dissemination of the infection would result. A grease consisting of petrolatum colored with bolus rubra was prescribed, and instructions were given that the preparation should be thoroughly rubbed on the scalp morning and night. The scalp was also to be vigorously shampooed with the aid of a hand brush (unless the scalp was too sensitive) before the grease was applied.

From the Skin and Cancer Unit of the New York Post-Graduate Medical School and Hospital, Columbia University.

1. (*a*) Lewis, G. M., and Miller, H. C.: Ringworm of the Scalp: A Report of Three Cases Due to Microsporon Lanosum with a Tendency to Spontaneous Recovery, Arch. Dermat. & Syph. **29**:890 (June) 1934. (*b*) Lewis, G. M.: Ringworm of the Scalp: Curability, Without Depilating Measures, of Infections Caused by "Animal" Microsporons, Am. J. M. Sc. **189**:364 (March) 1935.

RESULTS

In seven children the response was as uniformly good as when strong antiparasitic remedies were employed (table). The scalps were clinically and microscopically free from the disease in an average time of eight weeks. Each child was also examined on two different occasions under filtered ultraviolet rays before cure was established. In another series of patients [1a] taken from the same economic stratum as were those reported on in this paper, the use of irritating topical applications did not yield superior results. Several other children who began the treatment herein discussed did not return, and we do not know whether they were cured or whether other medical advice was sought. The treatment was discontinued in one instance when the infection spread to other parts of the body. In no other instance was the treatment considered a failure.

Results of Treatment with a Bland Application in Seven Patients with Tinea Capitis Due to M. Lanosum

Patient	Age	Sex	Duration of Infection	Number of Patches	Time Necessary for Cure
R. B.	7	F	2 weeks	1 large area	9 weeks
F. S.	5	M	8 weeks	1 large area	6 weeks
J. S.	9	M	4 weeks	1 large area	12 weeks
R. D.	9	M	6 weeks	Disseminated	6 weeks
J. M.	7	F	5 weeks	1 large area	7 weeks
A. H.	9	F	9 months	Disseminated	7 weeks
J. R.	3	F	4 weeks	Disseminated	9 weeks

COMMENT

This experiment shows that cure of some infections with M. lanosum may be brought about by mechanical measures; the fact that cure in these patients did not take longer than when strong fungicidal remedies were used suggests that epilation of scalp hair constitutes the sole method of cure in these infections. This is further substantiated by the invariably complete epilation of hair in cases in which the infection has disappeared. The hair tends to become loosened primarily by the follicular inflammation always present in infections of the scalp of this type. The process may be further aided by manual massage when the grease is applied and the loosened hair is removed by the shampoo. If the follicular inflammation is great enough, spontaneous cure results. If there were a direct medicinal effect on the fungi around the hair shaft from a topical application, the reason for the resistance of infections with Microsporon Audouini as compared with those with M. lanosum would be more difficult to explain. In infections with M. Audouini, the lack of follicular inflammation appears to be sufficient to explain the

lack of loosening of the hairs even when irritant applications resulting in a diffuse reaction (erythema, scaling) have been made.

It is suggested that in directing the treatment of patients with ringworm of the scalp due to microsporons pathogenic to animals, stress should be laid on the thorough washing of the scalp (preferably with a brush) at frequent intervals. The optimum length of time between shampoos appears to vary with the patient. In a patient observed in private practice, the infection persisted for ten weeks without any noticeable improvement. The scalp of the child had been washed diligently twice daily; this appeared to rub off the ends of the infected hairs without producing epilation. When the period between shampoos was lengthened to three days, a prompt and favorable response was obtained. An ointment containing an active fungicide should also be applied twice daily to prevent dissemination of the infection to other parts of the scalp or of the body or to other children and also to increase the inflammation around the follicles so that epilation of the infected hair may be expedited.

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DERMATOLOGY IN ART

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Art and medicine—they are both aspects of human civilization and yet it would be difficult to imagine two more different fields of human activity. Art—creation of an imaginative mind which, stirred by an experience or emotion, feels the urge to express itself in aesthetic forms; and medicine—a service, the endeavor of a man to succor his fellowmen by curing and preventing disease—Sigerist.[1]

A physician, especially if he is untrained in the true technic of art, is sorely tempted to survey the efforts prompted by this muse with a professional and evil eye. He is liable to violate that time-honored rule that the layman's appreciation of art should be with a check-book and respectful silence. Moreover, "whenever a doctor goes on a vacation trip to Europe accompanied by a wife who insists on seeing the galleries, he spends his time hunting for pathological subjects, is sure to make a 'discovery' and to write a paper about it."[1] Even the wise men in medicine are not above reproach, for Sigerist[1] reports that at a meeting of the International Congress of the History of Medicine in Madrid the members went to the Prado.

It was like a ward-round in a hospital, you heard nothing but medical comments. El Greco was a fine case of astigmatism, and in front of certain paintings of Velasquez regular clinics were held on disturbances of metabolism, cretinism, and what not. I am waiting for the papers to appear.[1]

Psychiatry in art has been reviewed.[2] In regard to dermatology, what could be more obvious in art than cutaneous lesions? In the galleries of statuary there are occasional dermatologic "specimens." The Greeks could be expected to create little which would be ugly. However, there is one statue that shows what is probably ulcerative carcinoma of the breast. Such examples are rare. The bust of Socrates[3] at the Capitoline Museum shows a nose which creates a slight suspicion of syphilis.

Of all the great sculptural beauties of Angkor-Vat in Indo-China, I choose for dermatologic purposes the statue of the leprous king

1. Sigerist, Henry E.: The Historical Aspect of Art and Medicine, Bull. Inst. Hist. Med. **4**:271 (April) 1936.

2. Trapp, Carl E., and Trapp, Mary C.: Psychiatry in Art, Ann. M. Hist. **8**:511 (Nov.) 1936.

3. Stickler, Georg: Entwurf einer Geschichte der ansteckenden Geschlechtskrankheiten, in Jadassohn, J.: Handbuch der Haut- und Geschlechtskrankheiten, Berlin, Julius Springer, 1931.

(fig. 1 *A*). The lepromas on the face are shown clearly. The clawlike hands may be the result of leprosy or of the weather. This statue was described by Jeanselme.[4] However, Dr. Armine Wilson has recently informed me that this statue does not show those markings about the mouth as definitely as they appear in the photograph. The statue is now believed to be one of Siva, a deity who forms part of the Hindu trinity. The carving about the mouth may represent a facial expression or even adornments.

In one of the reliefs on the Bamberg Cathedral (Germany), "The Devil with the Damned,"[5] several faces revealing signs of paresis are evident. An example of the rococo period and one which is of

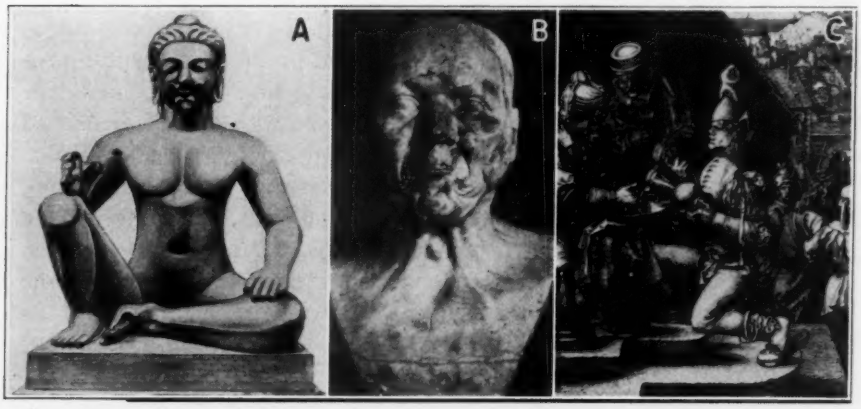

Fig. 1.—*A*, Statue of "The Leprous King," Angkor-Vat, Cambodia; *B*, "Deeply Hidden Sorrow," Baroque Museum, Vienna, Austria (Messerschmidt, 1770-1780); *C*, "Servant of Pontius Pilate" (Dürer).

interest to dermatologists is a character study by Messerschmidt,[5] "Der tiefverborgene Kummer" ("Deeply Hidden Sorrow") (fig. 1 *B*). This title destroys the first impression, of nodular leprosy or, possibly, lymphoblastoma. For the sake of future medical dilettantes I trust the title to this bust will not be lost.

The pottery of ancient peoples is made too crudely for the recognition of cutaneous lesions. American examples of pre-Columbian[6] water jars showing, supposedly, leishmaniasis, verruca peruana and goundou are interesting examples of art but poor representations of cutaneous disease.

4. Grön, K.: Lepra in Literatur und Kunst, in Jadassohn, J.: Handbuch der Haut- und Geschlechtskrankheiten, Berlin, Julius Springer, 1930, vol. 10, pt. 2.

5. Hamann, Richard: Geschichte der Kunst, Berlin, T. Knaur Nachf, 1933.

6. Moodie, Roy L.: The Antiquity of Disease, Chicago, University of Chicago Press, 1923.

Paintings should be easier of dermatologic analysis. There have been many false diagnoses of cutaneous syphilis on early canvases. The artist, even if he is of the pictorial school, is no better than the illustrators of some dermatologic textbooks. The pictures under discussion for syphilis have usually been of sores on the legs, and such lesions, objectively, may be anything from varicose ulcers to artefacts.

An excellent copper plate of Albrecht Dürer [8] is the "Servant of Pontius Pilate" (fig. 1 *C*). The nose of this servant is a favorite example of nasal syphilis. Unfortunately, 1512 is the date of this plate.

"The pathos of disease appealed to the artist," [1] and naturally leprosy would be a popular subject. Famous examples are Botticelli's "Sacrifice

Fig. 2.—*A*, "Satan Strikes Job with Leprosy" (Wechtelin, 1517); *B*, "Job" (Lucas Von Kranach).

of the Lepers" and Rubens' "St. Martin." The "Lepers" of Nicolas Emanuel Deutsch is another good representation. Many of the paintings purporting to show leprosy do not give either wholly characteristic lesions or enough details. An extreme illustration of this is Rembrandt's famous studies in shadow with his leprous beggar.

Domenico Theotocopuli (El Greco) is still copied by modern artists but has left nothing for dermatologists except the crude suggestion of argyria in many of his subjects. I have looked through several series of the "Totentanz" of Holbein [7] but find more of interest in osteology than in dermatology. The portrait of "Sir Thomas Moore" by Holbein [8] shows definite acromegaly. In the fifteenth century rhinophyma was painted by Domenico Ghirlandajo in his "Old Man and Boy."

7. Holbein, Hans: Totentanz: Liebhaber Bibliothek (facsimile), Munich, George Hirth, 1903.

8. Rujon, M. Henri: Hans Holbein, Paris, Pierre Lafitte et Cie.

As one might expect, pictures inspired by the story of the troubles of Job provide an interesting study of dermatologic lesions. I present two examples, one plate by Wechtelin [8] (fig. 2 *A*) and the other by Lucas von Kranach [8] (fig. 2 *B*). From these two examples one can see how difficult it is to make a diagnosis from a picture. From the hopeless prognosis printed on the first picture—"Benedic Deo et Morere"—one sees that the eruption must be something more than simple pyoderma.

Fig. 3.—"The Harlot's Progress" (Plate IV, William Hogarth).

In the other picture are Job's three friends, Eliphaz, Bildad and Zophar, who come as a lodge committee. They all stay at a respectful distance from him as Job's wife relieves the burning of the skin with water. There seemed to be no knowledge at that time of colloid baths. Even a physician so advanced as Marat seemed to know nothing of bran baths.

A painter of the Dutch school who gives much pleasure is Franz Hals.[9] One can almost hear the shouting laughter on his canvases. In "The Happy Trio" the owlish-looking bon vivant has a pigmented mole on his forehead. The picture is painted so clearly and carefully that there appears to be no gross evidence of cancer.

9. Rujon, M. Henri: Franz Hals, Paris, Pierre Lafitte et Cie.

At the end of the baroque period is the humor of Hogarth,[10] who has sometimes been called the best of painters if not of thinkers. One of his special objects of scorn seems to have been the physician, and the famous example of this is the "Consultation of Physicians," with its caption "et plurima mortis imago." One of the physicians in the lower right part of that picture shows a "questionable" syphilitic nose. Another moral theme of his is presented in the pictorial story "The Harlot's Progress" (fig. 3). This picture shows the girl in the workhouse, and the cutaneous lesions sketched on the faces of her associates may well be syphilis and not acne. One of the women on the right side of the picture seems to have a destructive lesion (gumma?) of her nose. The woman behind the heroine has palsy of the right side of the face. One can see cutaneous lesions in the fine engravings of Hogarth's other moral series, "The Rake's Progress" and "Marriage à la Mode."

Again to illustrate into what pitfalls a dermatologist may come by simple objective picture gazing, I have chosen the "Woman with a Pearl." I take that painting from Corot in preference to his exceptional landscapes. The woman in that picture may be Italian, Breton or even gypsy. She has even been flattered as the Mona Lisa of the impressionists. With the beautiful colors of this painting one would think, without the title, that the object on the forehead was an extensive filiform wart, a mole or even a cornu cutaneum. Fortunately, it is nothing so unromantic or interesting. It is simply a pearl.

With Corot one dips somewhat into that forbidden subject the moderns. The various "isms" of modern art offer little to the dermatologist besides utter confusion. The study of these artists seems to belong to the psychiatrist. After much searching I found one of Picasso's[11] harlequins, "Harlequin, from the Front" (1923), in which there seems to be suggested an extensive hemiatrophy. Even in surrealism something can be picked out. In Dali's[12] "Remorse" the slipper and the goblet in the skin of the back could be classified as foreign body tumors. I plead only that my explanations are no worse than some of the "interpretations" of the various moderns. With the trend of modern art to more conservative lines and more vivid colors, dermatologists again may pursue their most inartistic but interesting quest.

In a rambling way I have chosen bits here and there. Many old favorites have been omitted. From a dermatologic point of view one sees how questionable is the value of the analysis of many of the pictures. It is easy to read into such pictures many of one's own prejudices. With my ignorance I have, in all probability, insulted art, the artist and often the subject.

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10. Nichols, John: The Works of William Hogarth, London, Baldwin Craddock and Jay, 1822.

11. Picasso-Kunsthaus, Zurich, Berichthaus, 1932.

12. Dali, Salvador, Vanity Fair, February 1935.

NAEVUS SYRINGADENOMATOSUS PAPILLIFERUS (WERTHER)

REPORT OF FIVE CASES

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Naevus syringadenomatosus papilliferus (Werther[1]), or naevus syringocystadenomatosus papilliferus, appears to be a rare dermatosis when judged by the few cases reported in the United States. Weidman[2] described a section showing the typical structure; the nevus was discussed by McCarthy.[3] The only case report from this country which we have found was published by Stokes,[4] who discussed the clinical and histologic features of the dermatosis and gave several references to prior investigations. Reports of cases from foreign countries are somewhat more numerous: the pathogenesis was well described by Gans,[5] Kyrle,[6] Dörffel[7] and Cardenal.[8] Recently, cases have been reported by Fessler,[9] Biberstein,[10] Dörffel,[7] and González Medina and Bigne.[11]

From the Skin and Cancer Unit, New York Post-Graduate Medical School and Hospital, Columbia University.

1. Werther, L.: Syringadenoma papilliferum (Naevus syringadenomatosus papilliferus), Arch. f. Dermat. u. Syph. **116**:865, 1913.

2. Weidman, F. D.: Unpublished notes on cutaneous pathology.

3. McCarthy, L.: Histopathology of Skin Diseases, St. Louis, C. V. Mosby Company, 1931, p. 366.

4. Stokes, J. H.: A Clinico-Pathologic Study of an Unusual Cutaneous Neoplasm Combining Naevus Syringadenomatosus Papilliferus and a Granuloma, J. Cutan. Dis. **35**:411 (Aug.) 1917.

5. Gans, O.: Histologie der Hautkrankheiten, Berlin, Julius Springer, 1925, vol. 2, p. 282.

6. Kyrle, J.: Vorlesungen ueber Histo-Biologie der menschlichen Haut und ihrer Erkrankungen, Berlin, Julius Springer, 1925, vol. 1, p. 260.

7. Dörffel, J.: Naevus syringo-cystadenomatosus papilliferus, Dermat. Wchnschr. **99**:1318 (Oct. 13) 1934; Zur Histogenese des Naevus syringo-cystadenomatosus papilliferus, ibid. **100**:229 (Feb. 23) 1935; **101**:855 (July 13) 1935.

8. Cardenal, C.: Zur Kenntnis der Histologie des Syringocystadenoma papilliferum, Arch. f. Dermat. u. Syph. **166**:315 (Sept.) 1932.

9. Fessler, A.: Ein Fall von Naevus syringocystadenomatosus papilliferus (Werther), Dermat. Wchnschr. **96**:680 (May 20) 1933.

10. Biberstein, H.: Ueber papilliforme Syringocystadenome, Arch. f. Dermat. u. Syph. **152**:602 (Dec.) 1926.

11. González Medina, R., and Bigne, J.: Siringocistoadenoma papilífero, Actas dermo-sif. **28**:197 (Nov.) 1935.

CLINICAL CHARACTERISTICS

Frieboes [12] gave a résumé of the clinical features of the disease. According to him, the favorite sites are the shoulders, the axillae, the genito-inguinal and surrounding regions and the hairy portion of the scalp. The lesions are rose-red papules of firm consistency from the size of a millet seed to that of a hemp seed, usually arranged in groups. Owing to their transparent nature, one or more vesicle-like inclusions may often be distinguished; these inclusions are from the size of a pinpoint to that of a pinhead and filled with clear fluid. In addition, the papules are umbilicated at their summit, being similar to lesions of molluscum contagiosum. (Because of this finding, solitary lesions of long duration clinically resembling lesions of molluscum contagiosum may prove to be nevi of the type under consideration.) The papules stand out discretely or form directly confluent plaques. In one case (Kreibich [13]) papillary growths were observed on the surface of such a plaque.

A process similar to naevus syringadenomatosus papilliferus is observed in the glands of the breast, in papillary cystadenoma of the ovary and in tubular cystadenoma of the vulva. The diagnosis of the last condition was difficult to exclude in one of our cases (case 4).

HISTOLOGIC FEATURES

Investigators are in general agreement that the dermatosis is a nevus. The pathologic observations were well summarized by Gans,[5] as follows:

> The coil glands are little altered as a rule, except that at times they may be somewhat dilated. The sudoriferous ducts become cystic in places and empty on the surface of a thickened but otherwise unaltered epidermis. The inner surface of these cavities and ducts . . . contains small finger-like projections that appear not unlike villi. The connective tissue follows these papillary outgrowths and is noted as a loose network composed of fine fibers. The epithelial lining of the ducts and cavities . . . of the sweat ducts is composed of two or more layers of cells: an inner columnar layer and an outer cuboidal layer. In the connective tissue of the papilliferous proliferations, typical nevus cells [as described in case 1] are often noted. Well formed plasma cells, sometimes in groups, may be observed in addition to mononuclear cells. Little or no inflammatory changes are observed. Cell detritus and mucus are present in the lumen of the ducts.

In the case reported by Stokes,[4] the nevus was considered to have occurred in conjunction with a granuloma. Stokes mentioned that various investigators have observed an associated plasmoma. As noted in the preceding paragraph, Gans described plasma cells as being part of the

12. Frieboes, W.: Grundriss der Histopathologie der Hautkrankheiten, Leipzig, F. C. W. Vogel, 1921, p. 186.

13. Kreibich, cited by Frieboes.[12]

pathologic process and not necessarily as belonging to any additional granuloma or plasmoma. We were able to confirm this observation in case 2.

It must not be forgotten that various irritants—physical, mechanical or chemical—may so traumatize the nevus as to bring about inflammatory processes, some of which may be of a granulomatous nature.

DIFFERENTIAL DIAGNOSIS

Naevus syringadenomatosus papilliferus should be differentiated from syringoma, adenoma and adenocarcinoma of the sweat glands.

In syringoma there is absence of proliferation of the epithelium of the ducts, papilliferous projections and associated cellular elements.

Adenoma and adenocarcinoma of the sweat glands may not be determined clinically. In adenoma the epithelium is not proliferative, but it may be so in adenocarcinoma. In neither condition are there any villous elongations within the lumens of the ducts or any concomitant plasma or nevus cells. These processes are also usually limited to deeper portions of the cutis.

REPORT OF CASES

CASE 1.—M. K., a girl aged 4 years, presented a lesion of the scalp which was noticed at birth. No treatment had been administered. There was a dime-sized irregular patch of alopecia on the right parietal region of the scalp. The skin in this area was shiny, yellowish white, devoid of follicular openings and apparently atrophic. At the upper pole was a pea-sized crusted firm red elevation. No fungi were observed on repeated examinations. At times, the area became inflamed and tender for a day or two and then returned to its usual state. The clinical diagnosis was nevus, but the type was undetermined. The atrophic area was thought to be the end-process of the same condition.

Two specimens of tissue were removed for histologic examination: (1) the elevated nodule was removed in toto; (2) a wedge of skin was also taken from the flat atrophic skin.

Histologic Structure of the Nodule.—Many dilated sweat ducts were observed to extend from the deep layers of the cutis to the surface. Numerous finger-like processes projected into the lumens of these dilated ducts. The dilated ducts were lined for the most part by two and occasionally by three layers of cells. Some of the cells were cuboidal, and the remainder were columnar. The connective tissue framework about this mass was loose and lacy, containing numerous cells, predominantly nevus cells, with few plasma cells. The epidermis over the lesion was lacking. At the edges the epidermis was acanthotic but showed no other change. The sweat glands were dilated, and within their lumens were disorganized cellular elements.

Under high magnification the nevus cells were observed to be much larger than the surrounding cells and of about the size and appearance of prickle cells. The nuclei were faintly stained, and the chromatin was loosely arranged (vesicular). The cytoplasm was somewhat homogeneous but was visible. In places some of these cell outlines could be distinctly seen. Some cells contained more than one nucleus.

Histologic examination of the smooth area showed no evidence of the nevus; only atrophy was noted.

This patient was presented before the Section of Dermatology of the New York Academy of Medicine.[14]

CASE 2.—G. D., a woman aged 22, unmarried, had noticed a lesion on her scalp for many years. There had been only a slight increase in its size over a period of years.

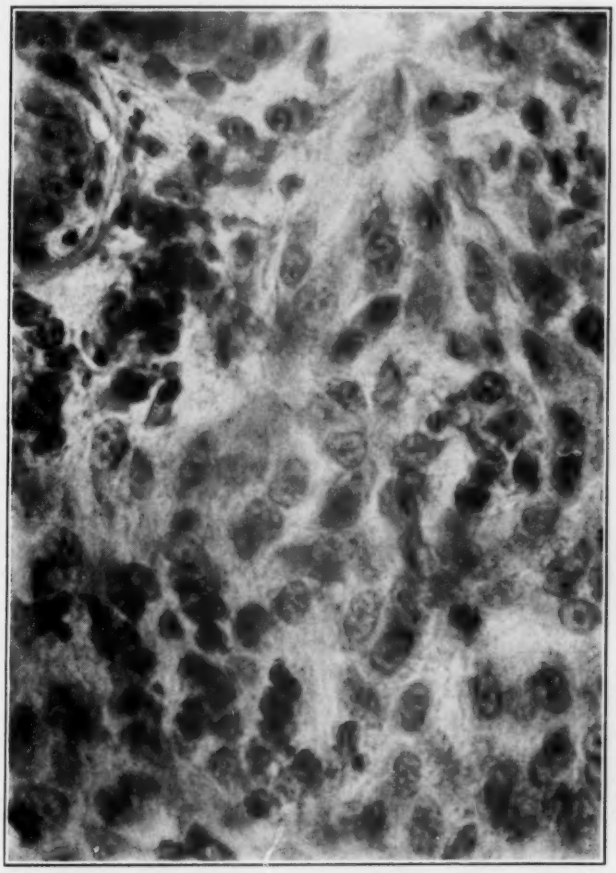

Fig. 1 (case 1).—High magnification, showing large faintly stained vesicular nuclei and definite cell bodies in nevus cells. There are also a few plasma cells.

There were no noteworthy physical findings except for the lesion on the crown of the head. This lesion was elevated, bean sized, the color of the skin and firm. The surface was irregular. The clinical impression was that the lesion was a verrucous nevus.

14. Lewis, George M.: Naevus Syringadenomatosus Papilliferus, Arch. Dermat. & Syph. **33**:920 (May) 1936.

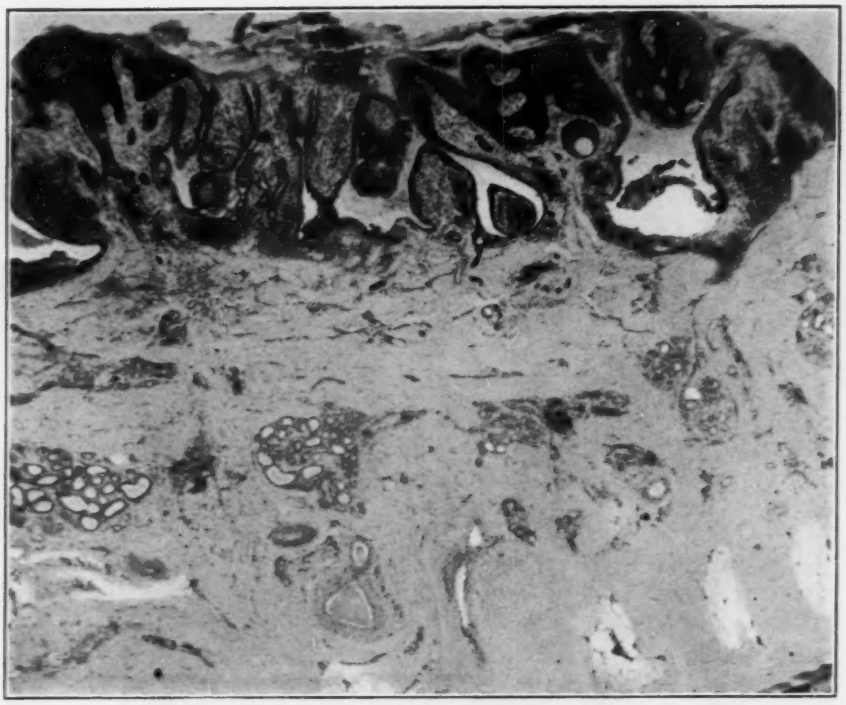

Fig. 2 (case 2).—Low magnification, showing general architecture.

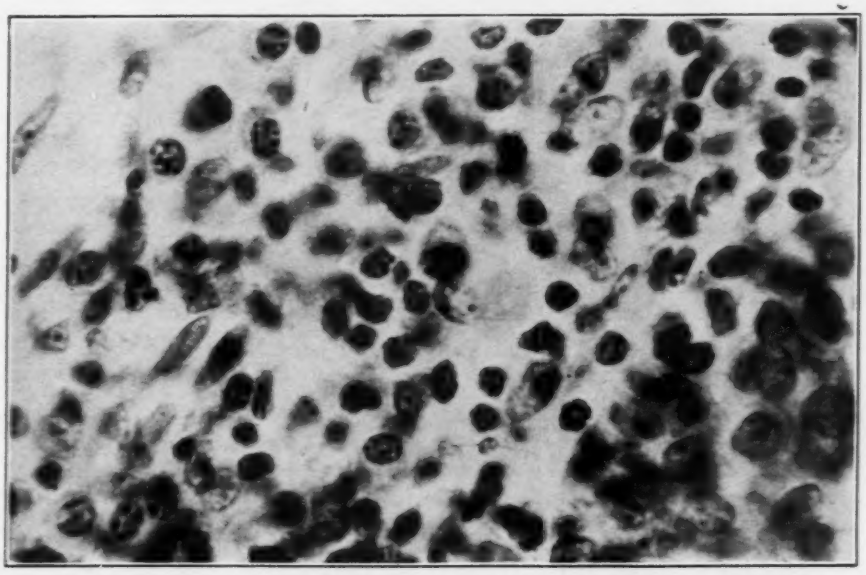

Fig. 3 (case 2).—High magnification, showing that plasma cells are present in abundance.

Histologic Structure.—The picture was essentially the same as in case 1, except that the sweat glands were considerably dilated and in places cystic. The hyperplasia of the lining of the ducts, the finger-like projections, the loose stroma and the cellular elements were all present. However, the cells were almost all of the plasma cell variety, and only an occasional nevus cell (of the type described in case 1) was seen.

CASE 3.—A. S., a man aged 49, a brush maker, had noticed a lesion on his upper lip for many years. There had not been any noticeable increase in size. He

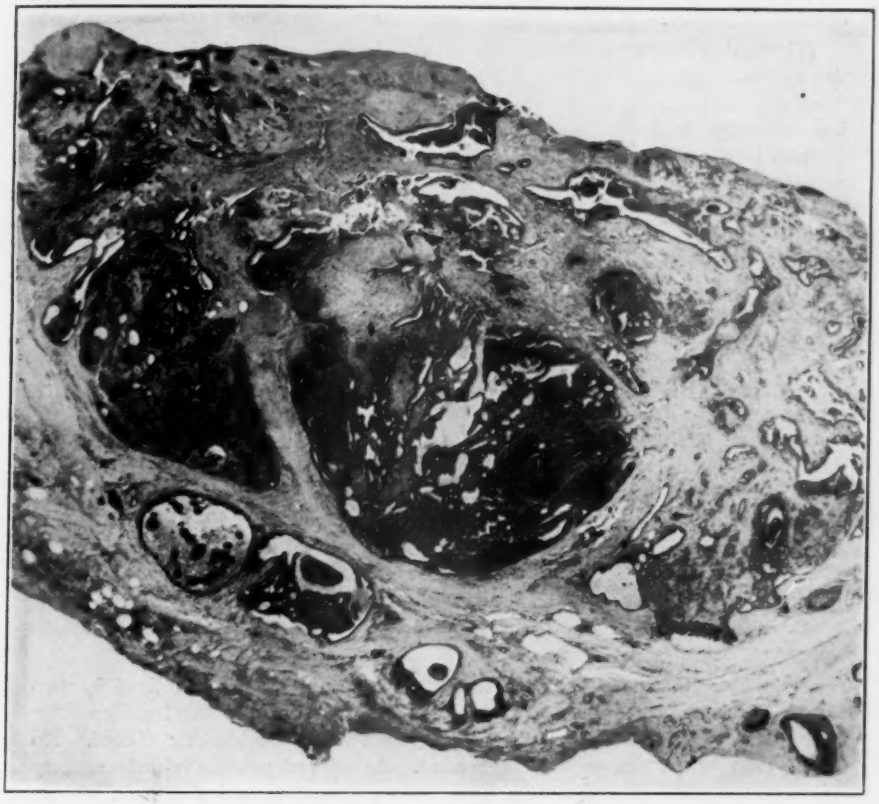

Fig. 4 (case 3).—Low magnification, showing a portion of mixed tumor containing the nevus.

was in good health, and physical examination failed to reveal any gross abnormality.

Examination disclosed a filbert-sized flesh-colored shiny lesion of rather firm consistency on the upper lip. There was no irregularity of the surface and no umbilication. The lesion was not bound to underlying structures. No pain was elicited on palpation. The clinical diagnosis was sebaceous cyst.

Histologic Structure.—The predominant process was that of a mixed tumor containing cartilage and bone. In the deep part there were numerous dilated

sweat ducts, lined by two and in places by three rows of cells. There were many small villous projections within the lumens of these dilated ducts. The stroma of this portion was loose and acellular. In other words, this portion of the process was similar to that noted in all the previously described cases except that the cellular elements were lacking.

CASE 4.—J. P., a housewife aged 37, first noticed a small lesion many years ago. There had been a slight increase in the size of the lesion. There were no subjective symptoms. On the right labium majus pudendi, there was a bean-sized firm nodule. The clinical diagnosis was fibroma. The entire lesion was excised by surgical diathermy.

Histologic Structure.—There were many dilated sweat ducts in the center of the section. The surface was papillomatous, and the overlying epidermis was wanting. At the margins the epidermis was present and considerably acanthotic, but otherwise it showed no important changes. The lining of the ducts was composed of two or three rows of cells. There were small villous projections extending into the lumens of the ducts. The lumens of the sweat glands were also dilated. There were some dense connective tissue, some dilated vessels and a cellular infiltrate composed of small round and plasma cells about the mass. The plasma cells in this section were considered to be due to the inflammatory reaction and were thought to be related perhaps to the fact that the lesion examined was taken from the vulva. (We do not believe that the plasma cells were part of the essential picture.) Nevus cells were not present.

Through the courtesy of Dr. Louis Chargin, we are able to report a fifth instance of this disorder.

CASE 5.—B. L., a man aged 39, stated that a small elevation appeared on his nose in 1933 and that at this time part of the lesion was surgically removed. When the patient was first seen by Dr. Chargin, in November 1936, the lesion was present on the left side of the nose near the nasolabial fold; it was round, pea sized and firm to the touch and bled easily. The surface was verrucous, and the middle portion was eroded. Whereas the clinical diagnosis was doubtful, the appearance suggested a prickle cell epithelioma. The lesion was excised, and to date there has been no recurrence.

Histologic Structure.—The sweat ducts were dilated and were lined by two and in places by three rows of cells. Small projections into the lumens of the ducts were noted. Many of the sweat glands were considerably dilated. No nevus cells or plasma cells were present. A marked productive inflammatory reaction composed of granulation tissue was observed around the mass. There were numerous dilated thin-walled blood vessels, a moderate cellular infiltrate and some fibrosis.

COMMENT

There are three main types of epithelial nevi associated with the epidermis.[15] The first involves the entire epidermis and is seen usually in the so-called hyperplastic verrucous epithelial nevus. In the second type there are numerous nevus cells in the upper and at times in the middle portion of the cutis. There is no direct connection with the epidermis proper. However, it is generally agreed that these cells origi-

15. Satenstein, D. L.: Unpublished notes on cutaneous pathology.

nate in the epidermis. The intracutaneous epithelial nevus exemplifies this form. The third variety is that seen in the melanoma. The seat of the process is at the junction of the epidermis and cutis. Nests of cells extending up into the epidermis are observed. Nevus cells extend from these nests of cells into the cutis.

The nevus cells observed in the melanomas and in the intracutaneous epithelial nevi are similar to those in naevus syringadenomatosus papilliferus. Therefore, it may well be that nevus syringadenomatosus papilliferus is a combination of intracutaneous epithelial nevus and nevus of the sweat ducts and sweat glands.

Dr. D. L. Satenstein studied all the specimens and corroborated the diagnoses.

SUMMARY

Five cases of naevus syringadenomatosus papilliferus are reported. In case 1 there had been an apparent spontaneous destruction of a large portion of the lesion. The remaining part was removed for histologic examination. The pathologic picture was typical of the dermatosis. In case 2 the condition was noteworthy because of the presence of plasma cells in the infiltrate around the cystic lesions. In case 3 the lesion had the clinical appearance of a sebaceous cyst; the nevoid process was deep and was associated with a mixed tumor. Case 3 further illustrated the nevoid character of the condition. In case 4 the lesion was present on the right labium majus pudendi, and the clinical diagnosis was fibroma. The histologic structure was similar to that of tubular cystadenoma of the labia. In case 5 the lesion clinically resembled a prickle cell epithelioma. Plasma cells were present in the infiltrate, but in this instance they were considered to be of inflammatory origin and not a part of the disease proper. In all five cases the dermatosis was solitary, and the treatment consisted of surgical excision.

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NAEVUS ACNEIFORMIS UNILATERALIS (NAEVUS FOLLICULARIS KERATOSUS)

WITH REPORT OF A CASE

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A rare type of nevus was first described by Selhorst [1] in 1896 under the title naevus acneiformis unilateralis. The first instance of the condition recognized in the United States was reported by White [2] in 1914, under the title naevus follicularis keratosus. In the foreign literature similar cases have been recorded occasionally, under descriptive names such as naevus acneiformis (Bettmann [3]), *naevus acnéique unilatéral en bandes et en plaques* (Thibierge [4]), systemized sebaceous gland nevus (Mayr [5]), naevus unilateralis comedo-follicularis (Hodara [6]) and *naevus zoniforme à comédones* (Montpellier et Colinieu [7]). Others have reported undoubted examples of this nevus, and mention should be made of the cases reported by Aoichi,[8] Meirowsky,[9] Klein,[10] Barber [11] and Anderson.[12]

This nevus was thoroughly and ably described by Sweitzer and Winer [13] under the title naevus unilateralis comedonicus in October 1932. About the same time Wise and Satenstein [14] reported another such case under the title naevus follicularis keratosus, giving an excellent description of the nevus and of the histologic findings.

From the Dermatologic Service of the Morrisania City Hospital.

1. Selhorst, S. B.: Brit. J. Dermat. **8**:419, 1896.

2. White, C. J.: J. Cutan. Dis. **32**:187, 1914.

3. Bettmann: Arch. f. Dermat. u. Syph. **80**:63, 1906.

4. Thibierge, G.: Ann. de dermat. et syph. **7**:1298, 1896.

5. Mayr, J. K.: Arch. f. Dermat. u. Syph. **141**:159, 1922.

6. Hodara, M.: Dermat. Wchnschr. **63**:1219, 1916.

7. Montpellier, J., and Colinieu: Bull. Soc. franç. de dermat. et syph. **34**:181, 1927.

8. Aoichi, M.: Jap. Ztschr. f. Dermat. u. Urol. **23**:30, 1923.

9. Meirowsky: Zentralbl. f. Haut- u. Geschlechtskr. **21**:399, 1926.

10. Klein, A.: Arch. f. Dermat. u. Syph. **124**:571, 1917.

11. Barber, H. W.: Brit. J. Dermat. **43**:137, 1931.

12. Anderson, N. P.; Ayres, S., Jr., and Kane, L. M.: Acta dermat.-venereol. **14**:299, 1933.

13. Sweitzer, S. E., and Winer, L. H.: Naevus Unilateralis Comedonicus: Naevus Follicularis of White, Arch. Dermat. & Syph. **26**:694 (Oct.) 1932.

14. Wise, F., and Satenstein, D. L.: M. J. & Rec. **137**:367, 1933.

Up to 1933 there were only four instances of this type of nevus recorded in the American literature. Since that time two additional cases have been presented at meetings of dermatologic societies in the United States.[15] My case is the third to be reported in this country since 1933, and apparently the seventh case in the American literature. Since naevus acneiformis unilateralis is such a rare condition, each new case seems worth recording.

A review of this subject seems proper, as several observers who have recorded cases have expressed somewhat contradictory ideas about the pathologic and clinical features of this nevus. Most observers have stressed the point that it is not a sebaceous gland nevus, since the lesions do not usually show the presence of sebaceous glands in microscopic sections. However, a few authors have reported definite histologic evidence of the presence of sebaceous glands, and such evidence was present in my case. I do not, however, consider the condition to be a sebaceous gland nevus, since the sebaceous glands appear normal in size and the pathologic changes are found in the follicle only.

In some of the reported cases there were definite inflammatory changes around the lesions, in most instances with scarring and atrophy of the skin as an end-result. In others there was no evidence of inflammation, and the condition was therefore an uncomplicated and unaltered example of this nevus. As stated by Sweitzer and Winer, an analysis of the cases of naevus acneiformis unilateralis indicates that they fall roughly into two groups: (1) those in which comedones only are present and (2) those in which the comedones undergo secondary changes, such as suppuration, formation of fistulas and follicular cysts and scarring.

In studying the cases of naevus acneiformis unilateralis recorded in the American and the foreign literature one is impressed by the fact that the lesions are confined to one side of the body, even though they are often extensive. They are usually present on the neck and the thorax, but they may occasionally be found instead on the face or the extremities. The lesions in all cases consist of grouped comedo-like papules, which are moderately elevated and give a feeling like that given by a nutmeg-grater. The presence of inflammatory papules, pustules and scarring around the nevus has been observed in most cases. In only a few of the recorded cases, among them the case which I am presenting, were there no inflammatory changes.

In several of the cases reported the condition was associated with pigmented patches around the nevus, as in the case of K. Yokoyama.[16]

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15. Senear, F. E., and Perlstein, M. O.: Naevus Unilateralis Comedonicus, Arch. Dermat. & Syph. **32**:680 (Oct.) 1935. Tolmach, J. A.: Nevus Unilateralis Comedonicus, Arch. Dermat. & Syph. **29**:461 (March) 1934.

16. Yokoyama, K.: Zentralbl. f. Haut- u. Geschlechtskr. **22**:67, 1927.

In a few cases there were associated tiny cysts in the skin near the comedones. Burnucci [17] reported a case of achromic nevus with comedones on the right side of the chest, the follicles being dilated and filled with bright yellow grains. In a few of the reported cases (Dreyer [18] and Brünauer [19]) there were nevoid lesions on both sides of the body, and for that reason the correctness of the diagnosis of naevus acneiformis unilateralis in their cases has been subjected to considerable doubt. In other cases presented at various times as examples of naevus acneiformis the condition proved to be naevus sebaceous or grouped non-nevoid acne comedones (Pautrier [20]).

C. J. White [2] insisted that these so-called comedones were not real comedones of sebaceous material. He stressed the point that the lesions did not contain the fatty material usually found in true comedones and that their contents were keratinized epithelial cells which could not be expressed. Most of the other observers who have reported cases, have noted this histologic feature of the keratinized contents of these comedo-like papules. Microscopic sections of the specimen obtained in my case showed the presence of a plug of this keratinized material in the papular lesions of the nevus.

At this point I should like to emphasize that the descriptive name naevus follicularis keratosus gives a correct histologic concept of this nevus, while the name naevus acneiformis unilateralis is a better descriptive name from the clinical point of view.

In most cases of naevus acneiformis unilateralis which were studied histologically, there were no pathologic changes in the epidermis. Sweitzer and Winer emphasized the fact that this condition is not a sebaceous gland nevus, since in the case reported by them there was complete absence of sebaceous glands in the involved areas. Wise and Satenstein noted a few atrophied sebaceous glands at the edges of the lesions in the case which they reported. Histologic study of the sections in the case which I am reporting showed definitely the presence of well developed sebaceous glands in their usual location in the cutis, near the base of the keratinized follicle (fig. 1). The presence of the sebaceous glands in my case definitely contradicts the opinion expressed by some previous presenters, that sebaceous glands are absent in naevus follicularis keratosus.

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17. Burnucci, F.: Arch. ital. di dermat., sif. **6**:26, 1930.

18. Dreyer: Zentralbl. f. Haut- u. Geschlechtskr. **26**:33, 1929.

19. Brünauer, S.: Dermat. Ztschr. **53**:91, 1928.

20. Pautrier, L. M.; Metzger, and Levy, G.: Bull. Soc. franç. de dermat. et syph. **32**:87, 1925.

In the discussion of a case of naevus follicularis keratosus presented at the December 1920 meeting of the Chicago Dermatological Society,[21] Dr. Otto Foerster stated that this condition could be included in the group of linear nevi which resulted from embryologic defect. I believe such an opinion can be readily accepted, especially in view of the rather characteristic somatic, linear or bandlike grouping of the lesions in most

Fig. 1.—Section from the affected area under low power magnification, showing keratinized plug in the follicle and sebaceous glands near the base of the follicle.

of the cases reported. In the article written by Sweitzer and Winer, the embryologic development of the hair follicles is reviewed, and Kyrle's classification of this nevus as a combination of homologous and heterologous hamartoma is accepted.

21. Senear, F. E.: A Case for Diagnosis, Arch. Dermat. & Syph. **3**:450 (April) 1921.

REPORT OF CASE

V. V., a white woman aged 22, born in Pennsylvania of Polish parentage, was admitted to the Morrisania City Hospital in August 1936 for the treatment of a primary lesion of the upper lip with an associated secondary syphilid. During the routine examination of the patient I noticed a large group of follicular comedo-like papules on the lateral aspect of the left side of the chest (fig. 2). These were arranged roughly as a bandlike quadrilateral figure at about the level of the fourth and fifth ribs and extended from the axillary region toward the posterior aspect of the chest for about 3 inches (7.5 cm.). The individual lesions were uniform in appearance and had the same color as the normal skin, without any evidence of redness, swelling, scarring, etc. The lesions consisted of small pinhead-sized, slightly elevated, conical papules, which were evenly distributed at distances of about 1/16 inch (0.1 cm.) from each other. When a finger was pressed over these

Fig. 2.—Naevus acneiformis unilateralis at the level of the fourth and fifth ribs. Maculopapular syphilid can be seen.

lesions, a distinct nutmeg-grater feeling was imparted. The entire nevus consisted of about nine groups of these papules, each group being roughly ¾ inch (2 cm.) in diameter, except for one group which was larger than the others. There was a narrow zone of normal skin between each two groups of papules. There was no tenderness, itching or other subjective symptoms. The patient had no acne vulgaris on her face or chest, and her skin was fine and smooth.

The patient stated that these papules on the left side of her chest had been present since infancy, and that neither the individual papules nor the groups of lesions had increased in size at any time. She was not interested in having these lesions treated, and she objected to surgical ablation of the affected area. A biopsy specimen was obtained from the center of a group of these papules, and the tissue was examined histologically.

Histologic Observations.—The sections were stained with hematoxylin and eosin, and under low power magnification (fig. 1) the epidermis appeared wavy and thinner than normal, and the papillary structure was flattened. There were

dilated follicles filled with cornified and lamellated material, and a plug of this material was present at the mouth of the follicle. Well developed, normal-appearing sebaceous glands were present in the lower part of the corium, around the base of the follicle.

Under high power magnification the structure of the dilated follicle and the laminated keratinization of its contents were distinctly seen. The sebaceous glands were not hypertrophied but appeared normal in size and structure. The base of the follicle was dilated and moderately acanthotic. There was no evidence of any inflammatory reaction in the cells of the corium. There were, however, numerous stellate or embryoniform connective tissue cells scattered throughout the upper part of the cutis, especially around the follicle and sebaceous glands, where they tended to be arranged somewhat in the form of a fibrous capsule.

DIFFERENTIAL DIAGNOSIS

Naevus acneiformis unilateralis should be differentiated from three conditions: (1) follicularis ulerythematosa reticulata, (2) naevus sebaceus and (3) grouped true acne comedones. The first is bilateral, symmetrical and not sharply defined and usually disappears spontaneously. The second is a true sebaceous gland nevus, caused by hyperplasia of the sebaceous glands. The contents of the follicles are sebaceous material, and they are not keratinized. The condition is usually found on the face and the scalp and is frequently in a linear arrangement and unilateral. No nutmeg-grater feeling is imparted by this nevus. The individual lesions are usually larger than those found in naevus acneiformis. The third condition develops during the adolescent period and is associated with acne vulgaris on the rest of the body. From the papules associated with this condition the sebaceous material can be expressed easily, which contrasts with the papules in naevus acneiformis unilateralis. Histopathologically there is an inflammatory infiltration, often including giant cells, and the follicular plug is not keratinized. These lesions are improved by the ordinary treatment for acne.

TREATMENT

Most observers have advised the surgical ablation of the affected area. However, in Mayr's case the lesions were surgically excised but new comedones appeared in the scar after several months. It is most probable that the follicular lesions were deep in this particular case and were not entirely excised, so that they recurred. In the case which was reported by Sweitzer and Winer the entire lesion on the left side of the neck was excised under local anesthesia, and the scar was scarcely noticeable. No success has been reported from the use of ointments. Roentgen rays or radium should have no beneficial effect on this nevus, since there is no inflammatory cellular infiltration and no hyperplasia of the sebaceous glands.

SUMMARY

A well marked example of naevus acneiformis unilateralis of the chest is reported, with lesions consisting only of follicular comedo-like papules and unaccompanied by any inflammatory changes.

The histologic examination showed the presence of sebaceous glands. This is in contrast to the findings previously reported by some other observers.

Drs. William Aronson and Jacob Taub, of the pathology department, prepared the histologic sections and the photomicrographs.

262 Central Park West.

ARTHUR VAN HARLINGEN

A PATRIARCH IN AMERICAN DERMATOLOGY

PAUL E. BECHET, M.D.
NEW YORK

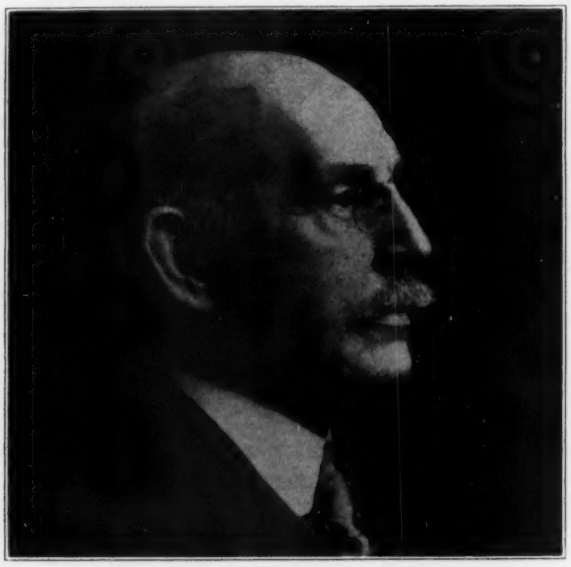
Great geniuses in any branch of human endeavor have the peculiar gift of frequently attracting and engaging in their service men of great intellectuality, excessive modesty, unbounded loyalty and indefatigable energy. That master dermatologist Louis A. Duhring was no exception to this rule, for in his choice of a close associate for many years he enlisted the subject of this sketch, who answered these requirements to their fullest extent. Van Harlingen was in a way the victim of his own qualities. His devotion to Duhring must have hindered his own interests to a considerable extent, and his innate modesty and reserve caused many who did not know him well to ascribe his aloofness to taciturnity and pride rather than to self-effacement. This tendency even at times prevented any extended airing of his views at dermatologic meetings. He was careful to be positive of the accuracy of his opinion before expressing it. Like most introspective men of great ability he was quick to discern the fallacious and ludicrous remarks occasionally made by self-seekers of notoriety at medical conventions, but he was too kind a man to criticize them openly. He was apt in repartee and had a well developed sense of humor.

His thorough training with Duhring, his care in the examination of every patient, his ability, acquired through long experience, to recognize a dermatosis by inspection alone and his splendid therapeutic results contributed to make him a brilliant dermatologist. His reputation became so great that he was occasionally consulted even years after his retirement, at his home in Rosemont.

Van Harlingen was essentially a clinician. As a pioneer in his field, he was a prominent member of a group of eminent dermatologists who made up for their lack of laboratory facilities by unusually trained, analytic and photographic minds, which, together with exhaustive clinical notes and an extraordinary development of what might be called "sight diagnosis," enabled them to differentiate correctly the many variations of the commoner dermatoses. This naturally developed a diagnostic acumen much neglected in the present day overdependence on laboratory reports.

Arthur Van Harlingen was born in Philadelphia on Oct. 25, 1845. He was the son of John Martin and Isabel Campbell Van Harlingen.

After he had received a preliminary education in the city of his birth—which must have been thorough, for he graduated from the Sheffield Scientific School of the Yale University at the age of 19—he matriculated at the University of Pennsylvania. He received from that institution the degree of Doctor of Medicine in 1867, at the age of 22. It was during his student days at the University of Pennsylvania that he first met Louis A. Duhring, a brilliant fellow student, just a month older than he, who was destined not only to affect profoundly his future career but to become a great leader of American dermatology. Both men became interns at the old Blockley Hospital immediately



ARTHUR VAN HARLINGEN

after graduation, and it was in that institution that Duhring first became interested in dermatology. It is plausible to infer that Van Harlingen's interest in dermatology also began at this time. As he was an intimate friend of Duhring, the latter's enthusiasm must have communicated itself to him, and he probably assisted Duhring in the so-called "skin ward."

Later he joined the famous Blockley brass sextet, which had been organized by Duhring, taking J. Ewing Mears' place. This band frequently entertained its audiences, composed of friends. They also played for the patients with mental diseases confined in the hospital, and Van Harlingen has commented on the soothing effect of the music

on these unfortunates. Besides Duhring and Van Harlingen, the band comprised Roland G. Curtin, Samuel S. Stryker, Isaac E. Roberts and A. W. C. Beecher.

After the completion of his term of service at the Blockley Hospital in 1869, Van Harlingen became a resident physician at the Pennsylvania Hospital and served for eighteen months. After leaving the Pennsylvania Hospital, he opened an office and engaged in private practice. Duhring, after completing his internship at the Blockley Hospital, left for Europe in July 1868, to seek special training in dermatology. After his return to Philadelphia he began the practice of dermatology in 1870, and a year later he was appointed lecturer on diseases of the skin at the University of Pennsylvania. He immediately sought out as his associate the friend of his student days, Van Harlingen, and thus the latter entered the specialty of dermatology. I should like to describe the circumstances in Van Harlingen's own words, written for me a few years before his death.

> Time and circumstances now brought us more closely together, and I had the opportunity to observe the thoroughness of his [Duhring's] method. I became his associate in the dispensary of the University Hospital. When I first began to work with him, and to study diseases of the skin under his guidance, I asked him one day what textbook I should study. "None," replied Duhring decidedly, "they will only confuse you. I found this to be the case. Hebra was incomplete; Wilson a mass of vague and contradictory statements. I would suggest," continued Duhring, "that you attend the clinics daily, study and examine each case closely, and after such an examination is made, let me give you the names of the disease and point out its diagnostic features." This advice, of course, I followed faithfully for two years, and I was then in a position to test the value of any work on dermatology. Our method of examination was most thorough. Frequently I have known Duhring to strip a patient and examine him from head to foot, dictating as he passed from point to point from the color, quantity and quality of the hair of the head down to the characteristic conditions of the soles. It was surprising what unexpected and interesting characteristics were brought to light by these exhaustive examinations. I have always felt that this training in accurate and complete examination has been of the utmost value to me.

Thus, so auspiciously, began the dermatologic career of the subject of this sketch. He rose higher and higher in Duhring's estimation, which was no mean feat in the eyes of any one acquainted with Duhring's character. From 1871 to 1885 Van Harlingen was an integral part of Duhring's career. He was the latter's chief of clinic at the University of Pennsylvania and helped him in the organization of the Dispensary for Skin Diseases at 216 South Eleventh Street. He made all the illustrations in Duhring's "A Practical Treatise on Diseases of the Skin," published in 1877; he read many of its proof sheets and made many

valuable suggestions. The preface of this book, which was the first authoritative American textbook on the subject, contains an appreciation of Van Harlingen's assistance in its preparation.

In 1885 Van Harlingen was asked to assist in the foundation of the Philadelphia Polyclinic, and he accepted the commission. He became the head of its department of dermatology and was its professor from 1895 to 1912.

Van Harlingen also served as clinical professor at the Jefferson Medical School. For seventeen years he was dermatologist at the Children's Hospital. He was present at the organization meeting of the American Dermatological Association at the University of Pennsylvania, on Wednesday, Sept. 6, 1876, and he became one of the charter members of that body and was elected to its presidency in 1907-1908. He served as secretary of the section of dermatology and syphilology of the international medical congress held in Philadelphia in 1876 in connection with the centennial celebration of that year. He became a fellow of the College of Physicians of Philadelphia in 1873; at his death he was the oldest living fellow.

Van Harlingen's literary work was not prolific, but what he published proved to be of much value and was always lucidly and clearly presented. His dermatologic interests, always essentially clinical, resulted in a number of case reports published in the *American Journal of Dermatology and Syphilology* and in the *Journal of Cutaneous Diseases* describing varied interesting dermatoses which he had observed while he was chief of clinic at the University of Pennsylvania. He also contributed freely to *The Photographic Review of Medicine and Surgery*, a monthly journal published from 1870 to 1872 by Louis A. Duhring and F. F. Maury. In 1884 he published a volume of his own, entitled "Handbook of the Diagnosis and Treatment of Skin Diseases." [1] This book was planned for the practitioner and not for the dermatologic expert. For this reason the commoner dermatoses were given much greater space than the rare ones. An alphabetical plan of arrangement was adopted in order to facilitate ready reference, and much space was given to treatment. The book was extremely well written and proved so popular that within a few years it ran through four editions, each of which was carefully revised. The third edition contains tables on the differential diagnosis of the commoner dermatoses which are of great practical value.

A prolonged period of ill health lasting about five years occurred when Van Harlingen was about 50 years of age and probably curtailed much of his literary output. That his recovery was complete, however,

1. The book was published in Philadelphia by P. Blakiston's Son & Co.

was well attested by the fact that he remained well until beyond 80, when even an attack of pneumonia had little effect on his robust constitution. His physical strength began to fail gradually in the last two years of his life, but his intellect remained clear and active until the end. His death, which occurred on Sept. 23, 1936, at the age of 91, removed a courteous, kindly gentleman of sterling qualities, an excellent teacher and a pioneer who accomplished much in the advance of American dermatology.

Van Harlingen's memory will never pass into oblivion as long as the specialty of dermatology lasts.

Clinical Notes

LEUKOPLAKIA AND TOBACCO

F. Ronchese, M.D., Providence, R. I.

Much has been written on leukoplakia buccalis, but so far no conclusion has been reached in regard to its cause.

As far as its connection with syphilis is concerned, medical writers have expressed opinions varying from a consideration of the association of the two conditions as merely accidental to a consideration of syphilis as an indirect cause or a direct one. The latter view is held in spite of the fact that antisyphilitic therapy has no effect on leukoplakia, that the percentage of syphilitic patients showing leukoplakia is small and that leukoplakia is rare in the Negro race, in which syphilis is widespread.

As for tobacco, with the exception of a few discordant voices, the opinion of authors is overwhelmingly in favor of considering smoking a direct cause of leukoplakia buccalis, in spite of the facts that leukoplakia is found in nonsmokers and in parts of the body other than the mouth and that it is rare among Negroes, although they smoke.

Two cases of clinically identical leukoplakia buccalis are reported, a heavy smoker being involved in one and a nonsmoking woman in the other, to cast doubt on the assumption that tobacco is one of the main causes of leukoplakia buccalis.

The term "smoker's palate" is particularly unwarranted.

REPORT OF CASES

Case 1.—A. B., a man aged 59, of English extraction, born in Rhode Island, a pilot, is an inmate of the State Hospital for Mental Diseases, suffering from a manic-depressive psychosis.

The patient is physically in good health. During the past three years he has noticed pinhead-sized rounded grayish elevations, centered by a "pore," on the roof of his mouth (fig. 1 *A*), which were diagnosed as leukoplakia.

The patient claims that for a number of years he has smoked an average of from seven to eight pipefuls of tobacco a day and has chewed tobacco most of the time when not smoking. He claims that the rash in his mouth is more painful when he smokes a great deal. When he has refrained from smoking and chewing for a while he feels comfortable again.

The Wassermann test was negative. The urinalysis showed no abnormality. When I saw the patient for the first time, one year ago, his palate was covered with elevations, while at present there are only a few. The patient has continued smoking and chewing.

Case 2.—A. V., a Negress aged 50, born in the Cape Verde Islands, shows pinhead-sized rounded grayish shining elevations, centered by a "pore," on the roof of her mouth (fig. 1 *B*). They have been present about ten years. On the middle of her palate there is a bony growth (torus palatinus). The patient has visited almost all the departments of the Rhode Island Hospital since 1916, complaining of dysmenorrhea, fatigue, pain in the back, dyspnea, etc. Repeated

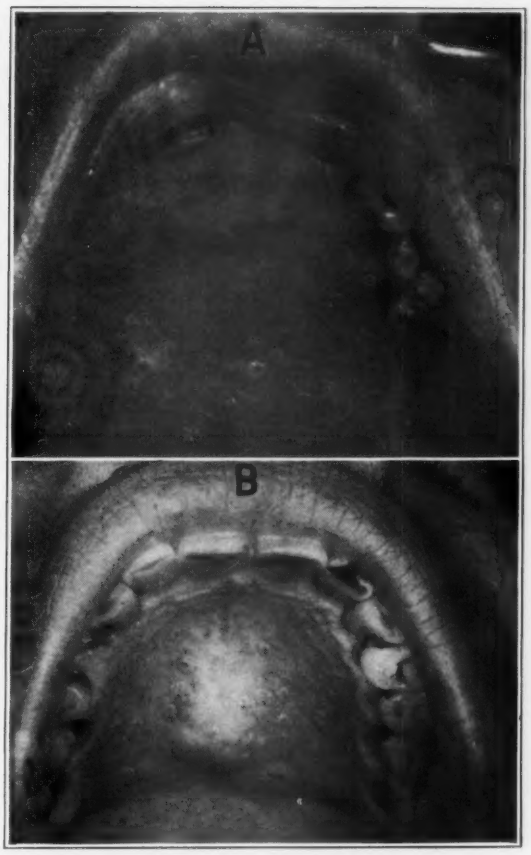


Fig. 1.—*A*, leukoplakia buccalis in a smoking man. *B*, leukoplakia buccalis in a nonsmoking woman.

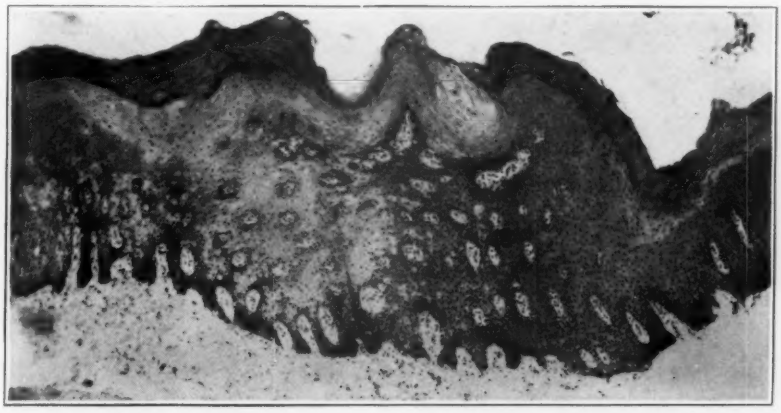


Fig. 2.—Section through an elevation of the palate in case 2, showing the histologic picture of leukoplakia.

Wassermann tests have given negative results, as have other examinations and laboratory tests. She says she has never smoked and does not eat hot or spicy food.

A flap of skin with one elevation was removed as a specimen for biopsy, and the following report was made by Dr. B. E. Clarke: "The epidermis is thick and rather irregular, and on the surface is a thick cornified layer. Beneath this is a small amount of fibrous stroma containing lymphocytes" (fig. 2).

A diagnosis of leukoplakia of the palate was made.

SUMMARY

Two cases of identical leukoplakia buccalis, one involving a man who smokes much and the other a nonsmoking woman, are reported, to suggest that the cause of leukoplakia is still unknown.

122 Waterman Street.

Minor Notes

TRICHOMADESIS
(Falling Hair)

HAROLD SHELLOW, M.D., CHICAGO

The term alopecia has been loosely applied to designate two related though actually different phenomena, namely, falling hair and baldness. The word alopecia is derived from the Greek *alopekia,* meaning mange of foxes, and is defined by medical dictionaries as baldness or partial or complete loss of hair. As defined by Pusey,[1] alopecia is baldness and "results not from the sudden falling out of individual normal-sized hairs, but from the fact that as the hairs fall out finer hairs regrow in their place, and this gradual decrease in size of the hairs continues until they finally cease to appear." Wilson[2] said that "loosening of the hair frequently occurs in young persons or those of the middle period of life and which, if neglected, would become real baldness."

The phenomenon that precedes baldness cannot be called alopecia, for that state does not actually exist. Many persons suffer from "falling hair," and for younger persons the term alopecia prematura is used. Aside from thinning of the hair, no actual baldness may exist, either in small, circumscribed patches or in larger ones, and it does not necessarily follow that baldness will exist.

For the phenomenon of falling hair I propose the word trichomadesis. Heller (cited by Strauss[3]) stated that Hippocrates used the word madesis to depict falling out, as in onychomadesis for falling out of the nails.

With the addition of tricho, meaning hair, to madesis, a word is coined that denotes the actual phenomenon of falling hair, just as words like trichorrhexis, trichauxis and trichoclasis denote definite changes in the hair which are readily understood. Adoption of this term would avoid the unsatisfactory use of the word alopecia and would be of value in the teaching of dermatology.

185 North Wabash Avenue.

1. Pusey, W. A.: The Principles and Practice of Dermatology, New York, D. Appleton & Co., 1920.

2. Wilson, Erasmus: Healthy Skin: A Popular Treatise on the Skin and Hair, London, J. A. Churchill, 1876.

3. Strauss, M. J.: Onycholysis and Onychomadesis, Arch. Dermat. & Syph. **26**:646 (Oct.) 1932.

News and Comment

SOCIETY NEWS

The meeting of the Mississippi Valley Dermatological Society, which was scheduled to be held in St. Louis on Dec. 4, 1937, has been postponed to make way for a meeting for organization of the American Academy of Dermatology and Syphilology, which will be held in Detroit.

MEETING TO ORGANIZE THE AMERICAN ACADEMY OF DERMATOLOGY AND SYPHILOLOGY

On Friday and Saturday, Jan. 14 and 15, 1938, a meeting will be held in Detroit, Mich., to organize an American Academy of Dermatology and Syphilology. The Detroit Dermatological Society will act as host to the Central States Dermatological Association, the Mississippi Valley Dermatological Society, the Chicago Dermatological Society and other local and sectional groups.

The business and scientific meetings and the banquet will be held at the Hotel Statler. A clinic will be held at the Harper Hospital.

AMERICAN BOARD OF DERMATOLOGY AND SYPHILOLOGY

Written examinations for candidates for group B certification by the American Board of Dermatology and Syphilology will be held in various cities throughout the country on April 16. Applications should be filed by February 15. Oral examinations for candidates in groups A and B will be given in San Francisco on June 13 and 14. Requests for information and applications will be handled by the secretary, Dr. C. Guy Lane, 416 Marlboro Street, Boston.

DEATHS

Dr. Harvey Parker Towle, of Boston, died on Thursday, Oct. 7, 1937.

Dr. Sigmund Pollitzer, of New York, died on Sunday, Oct. 31, 1937.

Abstracts from Current Literature

EDITED BY DR. HERBERT RATTNER

SEQUEL TO TREATMENT WITH PHOTODYN. H. F. BLUM and H. J. TEMPLETON, J. A. M. A. **108**:548 (Feb. 13) 1937.

Blum and Templeton report that a middle-aged housewife had received eighteen injections of a commercial product of hematoporphyrin hydrochloride for melancholia. After exposure to sunlight, wheals developed in the regions of the sites of the injections on her arms. In twenty-four hours the wheals had disappeared, leaving erythema. This erythema persisted for two or three days and was followed by brown pigmentation. Five months later the pigmented areas were still present, but they had faded somewhat. The same sequence of events, namely, formation of wheals, erythema and pigmentation, was noted by Blum and Templeton on numerous occasions when hematoporphyrin hydrochloride was injected into the skin of a normal person and the injection was followed by exposure to ultraviolet rays. The sensitivity in the area into which injections have been made may persist for as long as nine weeks.

DERMATITIS MEDICAMENTOSA RESULTING FROM ADMINISTRATION OF SULFOCYANATES IN THE TREATMENT OF HYPERTENSION. T. W. BAKER and L. A. BRUNSTING, J. A. M. A. **108**:549 (Feb. 13) 1937.

Although the sulfocyanates have fallen into disrepute as therapeutic agents of permanent value in the treatment of hypertension, they are still found in proprietary preparations designed to lower the blood pressure. Scant attention has been paid to the dermatoses which may follow the ingestion of sulfocyanates, and Baker and Brunsting were able to find only nine reports of such intolerance in the literature. In the case which they report a man aged 55 years ingested 5.4 Gm. of the drug in eleven days. An eruption then developed affecting all parts except the palms and soles. The eruption was of acute papulo-urticarial type and nonpruritic. There were an associated edema of the eyelids, a moderate conjunctivitis, a moderate congestion of the pharynx and swelling of the uvula. From a consideration of this case and from descriptions of other instances in the literature, Baker and Brunsting conclude that toxic dermatoses due to intolerance to sulfocyanates may resemble either the toxic erythema seen in acute arsenic poisoning or the papulopustular eruption following iodide therapy. Residual pigmentation may be present for several weeks.

LEWIS, New York.

VIRUSES IN THE AETIOLOGY OF SKIN DISEASES. R. T. BRAIN, Brit. M. J. **1**:934 (May 9) 1936.

Two main types of cutaneous lesions are produced by filtrable viruses, the hypertrophic or tumorlike and the vesicular or pustular type. The principal pathologic manifestation of virus lesions is the presence of the inclusion bodies; nuclear, as in herpes, or cytoplasmic, as in molluscum contagiosum. With special staining methods the virus particles themselves have been observed in the fluid from vesicles and other lesions. In establishing proof of source, the species specificity of the virus may explain the difficulty of transmission in animals. Through the development of specific antibodies these difficulties may be partly overcome. The virus bodies can be agglutinated by the serums of convalescent patients and can fix complement in the presence of such serums.

The author has investigated herpes, zoster, varicella and molluscum contagiosum. With the complement fixation reaction, he has shown that specific antibodies of herpes are present in the serum of those who are affected by the disease

but absent in those of persons who never had it. By this method, using the fluid of vesicles as a source of antigen, he has confirmed the observations of previous workers of the close relation between the viruses of zoster and of varicella. In serums from five patients with warts he did not obtain complement fixation; he did obtain it in two of six cases of multiple mollusca. The reactions to precipitation and agglutination tests were negative in all six. Complement fixation and precipitation tests in cases of dermatitis herpetiformis and psoriasis gave no specific results, and animal inoculation of material from patients with pemphigus vegetans and bullous erythema multiforme was unsuccessful. APPEL, Boston.

INVESTIGATIONS ON THE PROBLEMS OF IMMUNITY AGAINST SPIROCHAETA PALLIDA IN GENERAL PARALYTICS TREATED WITH MALARIA. A. BECK, J. Ment. Sc. **82**:254 (May) 1936.

Improvement in dementia paralytica after treatment with malaria is due to the disappearance of the spirochetes from the brain. The question remains as to what in malaria treatment causes this. At first it was thought that the high fever produced by malarial infection killed the spirochetes, but apparently this is not so, as improvement has been observed in cases in which the fever was mild. It is known that fever, no matter of what origin, causes an increase in normal and immune antibodies. A series of experiments was undertaken to determine whether an increase in syphilitic antibodies causes the cure.

Examinations were made of the behavior in vitro (immobilization and eventual agglutination) of Spirochaeta pallida in the presence of serum and cerebrospinal fluid from patients with dementia paralytica who had been treated with malaria. Examinations were also made in vivo for the existence of a bactericidal substance (spirochetocidin) and a phagocytosis-enhancing substance (spirochetotropin) in the serum and cerebrospinal fluid of patients with this disease.

The samples of blood and cerebrospinal fluid were taken from patients who had undergone treatment with malaria from two to six months before. Beck chose patients who had shown clinical improvement. Normal persons were used as controls to check the results.

All the experiments gave essentially negative results, thus presenting conclusive evidence that cure in dementia paralytica after treatment with malaria is not due to the presence of special immunologic bodies in the serum of patients with this disease. Beck concludes that the good results are due to the inflammatory reaction of the brain to the malaria. This is supported by the histologic evidence of other observers, who found an increase in the inflammatory reaction of the brain and in the aminonitrogen in the cerebrospinal fluid, pointing to increased destruction of cells. The exact mechanism of the inflammatory reaction of the brain and the mechanism by which the fight between the spirochetes and the cells takes place are still obscure.

KASANIN, Chicago. [ARCH. NEUROL. & PSYCHIAT.]

THE TREATMENT OF STAPHYLOCOCCAL SKIN LESIONS WITH TOXOID. L. E. H. WHITBY, Lancet **1**:1454 (June 27) 1936.

Whitby found that staphylococcus toxoid injected intramuscularly gave good clinical results in a high proportion of patients with recurrent and resistant furunculosis and was useful in the treatment of styes and carbuncles. The optimal dose of toxoid was found to vary with the subject.

LANGMANN, New York. [AM. J. DIS. CHILD.]

ANÆMIA WITH PIGMENTATION OF THE SKIN: COLLAPSED LEFT LOWER LOBE. G. H. NEWNS, Proc. Roy. Soc. Med. **29**:1209 (Aug.) 1936.

A boy of 7 years had been admitted to the hospital in August 1932 with a history of repeated attacks of abdominal pain of two years' duration, with the

intermittent passage of pale loose stools. For six months there had been increasing pigmentation of the skin of the face, the trunk and the limbs, and the child had lost considerable weight. The results of physical examination at the time of admission are given in detail. The stools at that time became loose and pale, and on account of this a diagnosis of celiac disease was made. The child was discharged and remained fairly well until March 1936, when he was readmitted to the hospital on account of cough and fever. Physical examination of the chest revealed dulness over the lower lobe of the left lung, with distant tubular breathing and intense whispering pectoriloquy. The results of investigations of the blood made at this time are given in the report. The Mantoux reaction was negative. A roentgenogram of the chest showed collapse of the lower lobe of the left lung.

WILLIAMSON, New Orleans. [AM. J. DIS. CHILD.]

PELLAGRA AND PELLAGRA-LIKE CONDITIONS IN WARM CLIMATES: SECTION III. HUGH S. STANNUS, Trop. Dis. Bull. **33**:885, 1936.

The author gives an interesting review of the literature on diseases among inmates of prisons or among natives in warm climates which he believes are pellagrous or closely related to pellagra. The following symptoms are enumerated: glossitis, consisting of fissuring and hypertrophy of the papillae or denudation of the tongue; similar lesions on the lips and the cheeks and excoriation of the angles of the mouth; gastro-intestinal disturbances; conjunctivitis, xerosis conjunctivae and xerosis corneae; erythematous or eczematous eruption on the scrotum or the vulva; pilosebaceous folliculitis surrounded by a hyperpigmented areola, situated particularly on the thighs, the arms and the shoulders; dry furfuraceous skin. Among the nervous symptoms described are: tremor of the tongue, sensations of tingling, heat, cold or numbness, impaired vision or hearing, ataxia and paresis of the limbs. Burning pains of the palms and the soles seem to occur frequently, and the author considers these of great diagnostic value. The literature on this symptom from 1825 up to date is cited.

Postmortem examinations in some cases have shown degenerated fibers in the posterior nerve roots and posterior columns, with scattered areas of degeneration in the lateral and anterior columns and in the anterior roots.

A number of the symptoms listed may be associated to form a series of syndromes, in some of which one or two symptoms seem to dominate the picture.

BLOOM, New York.

SUPPLEMENT TO THE HISTORY OF SWINE ERYSIPELAS (HUMAN INOCULATION OF THE BACILLUS OF SWINE ERYSIPELAS). G. BELGODERE, Ann. de dermat. et syph. **6**:193 (March) 1935.

An employee of a salt provision business in moving some pork barrels sustained a scratch on the right thumb, and mild erysipeloid developed. The case is described in detail. Organisms could not be demonstrated in the blood by microscopic examination, culture or animal inoculation with the blood, which is usually the case in this disease, but an emulsion of the bacillus of swine erysipelas, with a titer of 1:80, caused agglutination. After healing, a test for cutaneous allergy gave a positive reaction. Belgodere thinks swine erysipelas in human beings is rare.

(NOTE.—I have observed erysipeloid frequently among pleasure and commercial fishermen of the Texas coastal region and do not agree with this writer in his belief that the infection in human beings is rare.—Abstracter.)

A CLINICAL AND HISTOLOGIC STUDY OF CUTANEOUS LEISHMANIASIS. L. MASCHKILLEISSON, L. NERADOV and RAPOPORT, Ann. de dermat. et syph. **6**:229 (March) 1935.

Nine institutional patients supposedly suffering from cutaneous tuberculosis were found to have cutaneous leishmaniasis instead and were studied by these

authors. The tubercles and infiltrations may present multiple clinical and microscopic pictures. There are both early and late stages of this disease. Cutaneous leishmaniasis with tubercles (lupoid type) may readily simulate different forms of lupus.

GANDY, Houston, Texas.

A SERIES OF FIFTY CASES OF LEINER-MOUSSOUS' DISEASE OBSERVED SIMULTANEOUSLY IN A NURSERY. P. LEREBOULLET and A. BOHN, Bull. Soc. de pédiat. de Paris **33**:373 (May) 1935.

In a nursery in which the infants had been free from cutaneous irritation, fifty cases of erythroderma exfoliativum occurred in five months. The disease first appeared on the buttocks in infants about 2 months old. It then spread over the diaper area and down the posterior surface of the lower extremities, as well as to the scalp, the face, the folds of the neck, the axillae, the inguinal regions and the areas behind the ears. It ran a benign, self-limited course, usually clearing up in about three months. It was not eczema. The possible etiologic rôle of enterococci, which were present in a number of stools examined, as well as that of fungi and of sensitization, are discussed. Changes in the infants' feedings had no effect on the course of the cutaneous disease, and oil, talc and bland ointments were used locally.

ECZEMA IN AN INFANT MUCH IMPROVED AFTER THE ADMINISTRATION OF SPLENIC EXTRACT BY MOUTH. PIERRE DELTHIL, Bull. Soc. de pédiat. de Paris **33**:397 (June) 1935.

A boy 9 months old who had eczema was given 40 drops of splenic extract daily by mouth. After one week of this treatment the eczema, which had made its appearance when he was 2 months old, showed marked improvement. The improvement lasted for two weeks, when the mother discontinued the administration of the extract because of a digestive upset. It was planned to resume this form of treatment, to observe whether the condition of the skin would clear completely.

FAMILIAL ACRODYNIA: PRESENTATION OF THE THIRD CHILD AFFLICTED. G. BLECHMANN and A. LECONTE, Bull. Soc. de pédiat. de Paris **33**:520 (Oct.) 1935.

Three brothers were afflicted with acrodynia at the ages of 10 months, 15 months and 1 year, respectively. Approximately fifteen months elapsed between the onsets of the disease in the three cases.

ECZEMA TREATED WITH SPLENIC EXTRACT; RECURRENCE. J. HALLÉ, Bull. Soc. de pédiat. de Paris **33**:678 (Dec.) 1935.

A 12 year old boy had had eczema since infancy. He was given subcutaneous injections of splenic extract and made progressive improvement over a period of three months. A short time later the eczema was as bad as before.

PROGRESSIVE LIPODYSTROPHY. L. BABONNEIX and BONS, Bull. Soc. de pédiat. de Paris **33**:688 (Dec.) 1935.

A girl 6½ years old had marked wasting of the subcutaneous fat of the face and the thorax, as contrasted with the well nourished lower half of her body. The peculiar condition began at the age of 5 years, after she had scarlet fever. The basal metabolic rate was low, and interferometric tests pointed to a disturbance in the function of the thyroid and thymic glands and of the gonads.

BENJAMIN, Montreal, Canada. [AM. J. DIS. CHILD.]

EXCRETION OF RENAL EPITHELIAL CELLS DUE TO BISMUTH AND ITS SIGNIFICANCE IN REGARD TO RENAL FUNCTION. F. LISI, Gior. ital. di dermat. e sif. **77**:705 (Oct.) 1936.

It is common during treatment with bismuth salts to observe epithelial cells of renal origin in the urine. Lisi has studied the renal function in ten subjects who constantly had renal cells in the urinary sediment. The elimination of salts and nitrogen was normal, except slight retention of chlorides, which could not be considered pathologic. This seems to show a certain impairment of the renal epithelium for the excretion of sodium chloride, and consequently, Lisi concludes, a close watch should be kept on the renal function in cases in which intensive bismuth therapy is required.

PARDO-CASTELLO, Havana, Cuba.

SENILE MACULAR PIGMENTATION. G. MIESCHER, L. HÄBERLIN and L. GUGGENHEIM, Arch. f. Dermat. u. Syph. **174**:106, 1936.

The authors examined 29 specimens of acquired pigmented macules in old persons. Clinically the lesions are divided into small macules (senile freckles), large macular lesions and leukomelanoderma. The lesions became more frequent with age, so that of persons between 80 and 100 years of age 97 per cent showed pigmented macular lesions. The histologic picture usually showed varying amounts of atrophy, with irregular distribution of pigment in ordinary basal cells. In two cases multiplication of dendritic melanoblasts in the basal layer heralded the onset of precancerous melanotic lesions. A large number of pigmented macules, especially on the hands, appeared on section to be rudimentary pigmented senile warts. Differentiation of ordinary harmless pigmented lesions from precancerous melanotic lesions and rudimentary senile warts can be made only microscopically.

BECKER, Chicago.

PRACTICAL IMPORTANCE OF GROOVED TONGUE. P. BERGGREEN, Dermat. Wchnschr. **102**:421 (April 4) 1936.

Grooved tongue is a congenital anomaly of the tongue consisting of a symmetrical segmentation of the surface. It often occurs in families. In reviewing the cases of 255,000 vistors to the University Dermatological Clinic in Berlin, Germany, Berggreen was impressed with the following facts in regard to grooved tongue ("Faltenzunge"): 1. The condition appeared to predispose the patient toward other lingual conditions, especially exfoliatio areata linguae and lichen planus of the tongue. 2. Grooved tongue is more frequently seen among patients with psoriasis than among normal persons. 3. In the course of fifteen years, twenty-one patients were observed who complained of painful tongue and in whom no pathologic condition other than grooved tongue was present locally. In a considerable proportion of these pernicious anemia was noted, and in some others diabetes and syphilis were found. The author concludes that grooved tongue predisposes to the localization of other conditions in this region.

CUTANEOUS METASTASES OF A MALIGNANT CHORIONEPITHELIOMA. J. J. ZOON, Dermat. Wchnschr. **102**:433 (April 4) 1936.

A case is reported in which nodules developed in a 33 year old woman on the volar surfaces of the toes eight months after a molar pregnancy. Histologic examination showed the typical picture of chorionepithelioma.

ANTHRAX SUPERIMPOSED ON A SOFT CHANCRE. M. W. BORZOW and A. A. FINKEL, Dermat. Wchnschr. **102**:433 (April 4) 1936.

The authors report a fatal case of anthrax in which the disorder followed a soft chancre as a secondary infection.

HEMORRHAGIC PURPURA IN INOCULATION MALARIA. JOSEF TAPPEINER, Dermat. Wchnschr. **102**:481 (April 19) 1936.

Though hemorrhagic purpura is not unusual in natural malaria, it is extremely rare in inoculation malaria. Tappeiner observed a woman in whom purpura developed after the fourth access of fever in the course of malaria treatment. In spite of this complication, she was allowed to have five more bouts of fever. Examination of the blood showed a normal thrombocyte count, ruling out thrombocytopenic purpura. The author concludes that the disorder was analogous to the purpuras seen in other infectious diseases and due to toxic damage to the capillaries.

DENTAL ANOMALIES IN CONNATAL SYPHILIS. MARIËLE DÖRING, Dermat. Wchnschr. **102**:483 (April 19) 1936.

The author finds specific changes of the teeth in connatal syphilis in the following "grades": (1) barrel and screwdriver teeth, (2) hutchinson teeth and (3) atrophy of the first molars. The changes most frequently seen belonged to the first group.

A DERMATOSIS, RESEMBLING THE NEVI SYSTEMATICI, ASSOCIATED WITH CHANGES IN THE COIL GLANDS: "DYSHIDROSIS LINEARIS." M. OTA and S. OBA, Dermat. Wchnschr. **102**:488 (April 19) 1936.

A 22 year old student suffered from a linear eruption of the right arm for five months before he came under observation. The disorder consisted of pinhead-sized papules, many of which were confluent. Histologic examination showed intradermal and subepidermal dilatation of the sweat ducts to form small bullae. The eruption cleared entirely as the result of bland treatment. The authors considered the condition to be due to a disturbance of the nervous system, probably in the ganglions.

VARICELLA FOLLOWING REPEATED ATTACKS OF HERPES ZOSTER. FRITZ WERNER, Dermat. Ztschr. **73**:204 (May) 1936.

An 8 year old girl had three attacks of herpes zoster, all involving the inner surface of the lower third of the left leg. Ten days after the last attack typical varicella developed. Werner concludes that the virus of herpes zoster cannot be the same as that of varicella.

THE PROBLEM OF THE DEVELOPMENT OF HERPES ZOSTER DURING A COURSE OF ANTISYPHILITIC THERAPY. S. BRAMBILLA, Dermat. Ztschr. **73**:264 (June) 1936.

A case is recited in which zoster developed during a course of antisyphilitic therapy. It cleared in a reasonable time, during which treatment was not interrupted. The author points out three possible interpretations of the onset: that it was (1) idiopathic and purely coincidental, (2) syphilitic or (3) due to medication. The first and second possibilities are difficult to rule out. The fact that the condition cleared while injections of arsphenamine continued is evidence against the third.

PATHOGENESIS OF CHONDRODERMATITIS NODULARIS CHRONICA HELICIS. KLAUS HALTER, Dermat. Ztschr. **73**:270 (June) 1936.

Halter reviews briefly the early literature on this condition and gives the history of and histologic observations in four cases. He concludes that a combination of several factors is responsible for the development of the condition. These consist of (1) local factors, such as peculiar anatomic development of the blood vessels and regional dystrophies, (2) general organic factors, especially a special lability of the vessel nerves, and (3) external thermic or mechanical factors.

CLINICAL AND STATISTICAL OBSERVATION OF PATIENTS WITH PRIMARY AND SECONDARY SYPHILIS FROM 1926 TO 1935. WERNER SCHMIDT, Dermat. Ztschr. **73**:285 (June) 1936.

From 1926 to 1935, 1,363 previously untreated patients with early syphilis were observed by the author. Data gathered during this period are presented statistically.

1. Most men were infected between the seventeenth and the thirty-sixth year and most women between the sixteenth and thirtieth year.

2. A primary lesion was not found in 16 per cent of the men and in 40 per cent of the women with secondary syphilis.

3. Anal chancres occurred in 5.3 per cent of the men.

4. Extragenital chancres were found in 6.5 per cent of the men and in 15.5 per cent of the women.

5. The most common location of extragenital chancre was around the mouth, and the tonsil was most frequently affected.

TAUSSIG, San Francisco.

DIETARY THERAPY FOR PSORIASIS IN CHILDREN. E. SCHIFF, Jahrb. f. Kinderh. **145**:299 (Nov.) 1935.

A 5 year old child with severe psoriasis was successfully treated by means of a fat-free diet. This diet consisted of fresh fruit, fresh raw vegetables and orange, tomato and carrot juices in small quantities. Cevitamic acid in the form of tablets was given by mouth regularly, and at one time cevitamic acid was given intravenously.

LANDAU, Hannibal, Mo. [AM. J. DIS. CHILD.]

THE PATHOGENESIS OF SCLERODERMA IN RELATION TO THE PARASYMPATHETIC FIBERS. KEN KURÉ, KENJI YAMAGATA and YOSHITOMO KANEKO, Klin. Wchnschr. **11**:1415 (Aug. 20) 1932.

In a study of the cutaneous nerves of sclerodermic areas the authors found that the small medullated fibers were most severely degenerated, while the large and middle-sized medullated fibers were intact or showed but slight changes. Because the parasympathetic fibers are small and medullated and in addition contain trophic fibers, the authors considered the possibility that the sclerodermic changes might be evoked through degeneration of the trophic or parasympathetic nerve fibers in the affected regions. They wondered, too, whether improvement might not be brought about by excitation of these trophic fibers. To ascertain this they made use in some cases of subcutaneous injections of 0.2 cc. of 1 per cent solution of pilocarpine and in others of the cutaneous application of a hydrous wool fat ointment containing 1 per cent pilocarpine; with the latter they used plain hydrous wool fat in another sclerodermic region as a control. They report five cases in adults and assert that the skin became softer and the pigmentation was reduced. The results were equally good with subcutaneous injections and with the pilocarpine ointment and became apparent in from one to three weeks.

SILVERMAN, Syracuse, N. Y. [AM. J. DIS. CHILD.]

THE USE OF DIATHERMY IN THE TREATMENT OF GENERALIZED PSORIASIS. V. A. LUKASHEV, Vrach. delo **18**:479, 1936.

Lukashev reports a typical case of severe generalized psoriasis of ten years' duration without remissions. Numerous methods of treatment had been used, but no improvement had been observed at any time. A course of generalized diathermy was then instituted. A complete clearing of the cutaneous process occurred after a course of twenty treatments, which were given every other day for periods of from twenty to forty-five minutes. A prophylactic course of treatments was given three months later. No recurrence of the disease had been observed up to the date of this report.

BODER, Los Angeles. [AM. J. DIS. CHILD.]

TREATMENT OF ERYTHRODERMIA DESQUAMATIVA (LEINER) WITH VITAMIN D. Y. KITAMURA, J. Pediat. (Tokyo), no. 345, Aug. 20, 1936, p. 1129.

Kitamura reports four cases of erythroderma desquamativum (Leiner), two of which occurred in homozygous twins, and reviews sixteen other cases reported in the Japanese literature. The majority of the reported cases were observed in boys under 3 months of age. The oldest patient was a 7 month old girl. Aside from the cutaneous lesions, one outstanding symptom was gastro-intestinal dysfunction, although the majority of subjects were breast-fed infants. The author's four patients were treated by administration of adequate doses of vitamin D and by strict regulation of feeding.

SEVEN CASES OF DERMATITIS EXFOLIATIVA NEONATORUM (RITTER). KAYO GI, J. Pediat. (Tokyo), no. 436, Sept. 20, 1936, p. 1320.

Gi reports his clinical observations on Ritter's disease. Four boys and three girls presented the disease during the first three weeks of postnatal life. In six patients the initial lesions were vesicular, only one patient showing a diffuse erythematous rash at the onset. One infant, a girl, from whose lesions a positive culture of Staphylococcus aureus was obtained, died; all the others recovered. There was slight leukocytosis with a relative increase in the number of eosinophils, the highest percentage being 31. Serologic tests and urinalysis gave negative results. Local treatment with zinc in oil or in starch, together with internal administration of viosterol, produced a favorable result.

KATO, Chicago. [AM. J. DIS. CHILD.]

DIASTASE IN THE SERUM DURING AN ECZEMATOUS CHANGE OF THE SKIN. K. KITAMURA and T. HONDA, Jap. J. Dermat. & Urol. **40**:143 (Oct.) 1936.

Kitamura and Honda investigated the content of diastase in specimens of serum from fifteen rabbits in which they produced dermatitis with croton oil. They found a diminution in the acute stage, a slight increase in the early period of the subacute stage and a marked increase in the end-period of the subacute stage. They expressed the belief that the dermatitis had produced a disturbance which caused these changes.

CONJUGAL INFECTION WITH THE VIRUS OF LYMPHOGRANULOMA VENEREUM. S. KOYAMA, Jap. J. Dermat. & Urol. **40**:149 (Oct.) 1936.

Among 170 cases of lymphogranuloma venereum Koyama found 9 cases of conjugal infection. All the men had inguinal buboes. The period of incubation was about four weeks. Of the 9 female patients, 7 had inguinal buboes, 1 had a rectal ulcer and 1 had no signs of infection except a positive Frei reaction. In the 7 women with the inguinal buboes the primary lesion was found on the external genitals, and in the patient with the rectal ulceration an ulcer was seen on the cervix. From the vaginal secretion of the latter patient the author produced an effective Frei antigen. He stresses the necessity of thorough examination of the wife of every patient with lymphogranuloma venereum.

BLOOM, New York.

NECROSIS ADIPOSA NEONATORUM. K. BOJLÉN and S. PETRI, Acta pædiat. **19**:123, 1936.

Approximately one hundred cases of necrosis adiposa neonatorum have been reported up to the present time. The disease has been described under a variety of terms: *Induration curable cutanée du nouveau-né par traumatisme obstétrical* (Marfan), *sogenannte Sklerodermie der Neugeborenen* (Mayerhoffer), *circumscripte, symmetrische Fettsklerose im Säuglingsalter* (Keilmann), sclerema neonatorum (Gray), traumatic necrosis of the subcutaneous fat of the new-born infant (de Val and Bolin), adiponecrosis subcutanea neonatorum (Carol and van der

Zande) and adiposclerosis subcutanea neonatorum (Nakagawa). The number of histologic examinations which have been recorded hardly exceeds twelve. Chemical and bacteriologic evidence relating to the etiology of the disease is scanty. As might be expected, numerous theories have been devised to explain the phenomenon; in these, emphasis is placed on obstetric trauma and on the effect of chilling. As to pathogenesis, Unselm holds that the essential feature is the splitting of neutral fats into their respective components. The fatty acids remain in the tissues either in the crystalline form or as calcium soaps. The subcutaneous fat of the newly born infant contains relatively large amounts of palmitic acid, a substance which has a higher melting point than either oleic or stearic acids and which combines readily with calcium. However tempting the theories, none has yet been proved.

Two cases of necrosis adiposa neonatorum have already been reported from Queen Louise's Hospital for Children, in Copenhagen, Denmark; a third case is presented from the same institution. The patient was an infant who was born asphyxiated; transitory fever and convulsions led to repeated intramuscular injection of whole blood obtained from her father. When the infant was 14 days old, ligneous infiltration of the subcutaneous tissues was detected in the region of the buttocks and thighs; the overlying skin exhibited a reddish violet hue; its temperature was not increased. The process continued to advance for about two weeks and by then had involved most of the back. Two weeks after the onset, as the last of the new lesions developed, the earliest ones commenced to resolve. The infant was entirely well less than four months after the onset of illness. Histologic examination of a piece of tissue removed from the affected area showed extensive necrosis of the subcutaneous fat, together with foreign body and reparative reactions. The histologic features were closely comparable to those recorded by previous observers.

Emphasis is placed on the benign prognosis for necrosis adiposa neonatorum and on the present complete ignorance concerning its etiology. The paper includes a tabular recapitulation of the cases previously reported in the Scandinavian literature, and a comprehensive bibliography is appended.

McCune, New York. [Am. J. Dis. Child.]

Society Transactions

SAN FRANCISCO DERMATOLOGICAL SOCIETY

L. R. TAUSSIG, M.D., *President*

Dec. 4, 1936

JOHN M. GRAVES, M.D., *Secretary*

A Case for Diagnosis (Drug Eruption?). Presented by DR. C. E. SCHOFF, Sacramento, Calif.

K. S., a school girl aged 13, presents numerous pigmented spots over the arms, the legs, the torso, the lower lip and a finger. These began two years ago after a fever, which lasted three days, during which time a lesion developed in the left iliac region. Since then pigmented areas have continued to develop, some accompanied with fever and others without any accompanying illness. Some of them show central depigmentation. No counterirritants which might have caused the formation of central white spots have been applied.

There have been no local subjective symptoms. An occasional purgation with magnesia magma is the only form of ingestion of drugs obtained in the history. The possible ingestion of phenolphthalein was taken up at length with negative results, as was the possibility of any medication with silver salts.

Physical examination showed absence of knee jerks; all other superficial and deep reflexes were present. The oral and vaginal mucous membranes were not involved, nor was the retina.

The Kolmer and Kahn tests were negative. Urinalysis gave negative results. There was no reaction to phenolphthalein. The blood count showed 4,925,000 red blood cells; 14.2 Gm. of hemoglobin, or 83 per cent, and 5,275 white blood cells. The differential count showed no abnormality, with the exception of 6 per cent eosinophils. Examination of the stools did not disclose any evidence of intestinal parasites or ova.

DISCUSSION

DR. H. E. MILLER: It is my belief that the patient has a phenolphthalein dermatitis, in spite of the fact that Dr. Schoff has been unable to secure a history of the ingestion of phenolphthalein.

DR. H. J. TEMPLETON, Oakland, Calif.: Aminopyrine might cause this type of reaction.

DR. F. G. NOVY JR., Oakland, Calif.: It might be a good plan to test the patient with large doses of phenolphthalein and see what the reaction would be.

Lupus Vulgaris with Hyperkeratosis. Presented by DR. CHARLES ALBERT SHUMATE for DR. HARRY E. ALDERSON.

W. S., a German-born man aged 73, presents lupus vulgaris of over fifty years' duration involving the entire left side of his face and neck and his left ear. The right side is less involved. On the left cheek is a keratotic lesion, 7 by 5 cm., with large horny elevations. Roentgen treatment was given many years ago.

The patient was seen in February 1934, by Dr. N. N. Epstein, who remarked that on the left cheek there was "hyperkeratosis of two months' duration—probably malignant." Histologic examination of the lesion revealed no malignancy, however. The lesion was destroyed and in April 1934 had healed.

On Feb. 19, 1935, Dr. Epstein again saw the patient and noted that the "large keratosis—probably malignant—on the left cheek had returned." Histologic exam-

ination again showed no malignancy. The lesion was curetted and electrodesiccated and by March 1935 had healed.

By March 31, 1936, the keratosis had recurred, and an ointment was prescribed. By November 1936 the lesion had grown to its present size. This lesion was believed by everyone at the clinic of the Stanford University Hospital to be malignant. Another biopsy specimen was taken, and a frozen section is presented tonight.

Roentgenograms of the patient's chest, the Wassermann test, urinalysis and blood counts showed no abnormality.

DISCUSSION

DR. CHARLES ALBERT SHUMATE: We thought this case was of interest because Dr. Epstein, who saw the patient in 1934 and again in 1935, on both occasions believed from clinical observation that the growth was malignant. However, histologic examinations showed it to be nonmalignant. The present condition clinically appears malignant, but the sections from a recently taken biopsy specimen show it to be only hyperkeratosis. We realize, however, that a section from another part might show malignant changes.

DR. H. J. TEMPLETON, Oakland, Calif.: In spite of the histologic picture, I am inclined to think that this lesion is malignant and should be removed.

DR. L. R. TAUSSIG: I agree with Dr. Templeton.

DR. N. N. EPSTEIN: I saw this patient at the clinic of the University of California Hospital in 1934 and in 1935, and the lesion looked just as it does today except that it was smaller. It it were malignant it should be of the squamous cell type. In all these years there has been no evidence of metastases. The lesion has acted benignly, in spite of its appearance, but I think it should be treated as if it were malignant.

Xeroderma and Postoperative Myxedema (Following Total Thyroidectomy). Presented by DR. N. N. EPSTEIN.

A. R., a white man aged 58, underwent total thyroidectomy for angina pectoris in October 1935. Bilateral paralysis of the recurrent laryngeal nerves and a tracheotomy complicated the postoperative course. Within the past seven months the skin over the entire body has become dry, rough, thickened and scaling. The process is most marked over the face, the neck and the extremities.

The basal metabolic rate, on Sept. 23, 1935, before operation, was —2 per cent; on Nov. 20, 1935, after operation, —22 per cent.

With regulated thyroid medication, from 1/10 to 1/4 (0.006 to 0.015 Gm.) daily, and the application of an ointment containing salicylic acid, the condition of the skin has greatly improved.

DISCUSSION

DR. G. V. KULCHAR: The lesions on the forearms were not quite typical of postoperative myxedema. They certainly were not the type reported by Pillsbury and Stokes as localized lesions. They look like those described by Frazier and Hu in China as lesions due to a deficiency in vitamin A. How long has the patient been taking thyroid?

DR. H. E. MILLER: I think the basal metabolic rate in this patient ought to be determined again. This has not been done since three weeks after operation, more than a year ago.

DR. E. A. LEVIN: I believe it ought to be emphasized that with the use of thyroid and of salicylic acid ointment the skin has greatly improved. The patient has been taking thyroid for about six months. He cannot be given adequate amounts, however, because of recurrence of anginal pain whenever the dose is increased.

Pustular Psoriasis. Presented by Dr. H. J. Templeton, Oakland, Calif.

C. W., a man aged 58, is presented, with a tentative diagnosis of pustular psoriasis. I have seen him twice when he has had acute exacerbations showing generalized dermatitis followed by exfoliation. Between attacks I have seen rather typical areas of psoriasis on his trunk and his legs. The fingers show extensive dermatitis and paronychia, the whole picture of the fingers resembling acrodermatitis perstans of Hallopeau. General physical examination has revealed no focus of infection or other pathologic condition. Urinalysis and blood counts gave normal results; the reaction to the Kline test was negative. Treatment has included long periods of rest in bed, a diet high in vitamins, administration of autogenous vaccine and autohemotherapy. Fractional doses of roentgen rays have been used on the extremities and other stubborn areas. During severe generalized flare-ups the patient has been placed in continuous baths. In the less acute phases, wet dressings of potassium permanganate have been used on the fingers and the toes and boric acid ointment, petrolatum and other bland applications on the rest of the body.

DISCUSSION

Dr. C. E. Schoff, Sacramento, Calif.: I should like to ask Dr. Templeton his basis for making a diagnosis of "pustular psoriasis."

Dr. H. J. Templeton, Oakland, Calif.: When one makes such a diagnosis one wonders indeed just what pustular psoriasis is and what relation it bears to acrodermatitis perstans of Hallopeau. I have seen this patient during several acute exacerbations, during which he presents a secondarily infected generalized dermatitis along with severe paronychia. When the generalized dermatitis subsides there remain silvery, scaly lesions rather typical of psoriasis and a pustular involvement of the nails. If only the nails were seen a diagnosis of acrodermatitis of Hallopeau would be inevitable, but the lesions of psoriasis plus the attacks of secondarily infected generalized exfoliative dermatitis seem to clinch the diagnosis of pustular psoriasis.

Dr. H. E. Miller: I should classify this condition as an exfoliating dermatitis. I could not make a diagnosis of psoriasis at the present time. I should like to ask Dr. Templeton how he expects to cure the patient.

Dr. H. J. Templeton, Oakland, Calif.: I have discussed specifically tonight with several members of the society the question of fever therapy. It is my intention to wait until the patient gets to the stage when he has only the psoriatic plaques and pustulation around the finger-nails and then to give him pyretotherapy.

Dr. H. E. Miller: It would be a mistake to give this patient pyretotherapy. He is not in good condition and is 58 years old. I do not believe pyretotherapy is of much benefit against psoriasis anyway.

Dr. N. N. Epstein: I do not think it would be worth risking extremely high temperatures on this patient; however, one could raise his temperature 1 or 2 degrees safely and with possible benefit. I have not had enough experience to know whether or not it would help.

Dr. G. V. Kulchar: I think this condition falls into the class of erythroderma following psoriasis. The fact that the man has reached the age of 58 does not mean that one should not try to cure his condition. One possible method of treatment would be generalized roentgen ray baths such as those given patients with lymphoblastoma. Fever therapy might be tried.

Phagedena Secondary to Periurethral Abscess. Presented by Dr. F. G. Novy Jr.

A. B., a white man aged 28, states that he has always been well except for his present illness. Off and on for the past ten years the patient has had a slight urethral discharge. He has always been told that this was not syphilitic. In December 1935 he had considerable bleeding and some discharge from the urethra. A slight discharge continued until February, when he noticed difficulty in urinating

and a lump appeared on the shaft of the penis. This became larger, so that he could hardly urinate, and the urine had to be "milked out." He was seen at this time by his physician, who opened the tumor, obtaining a small amount of pus and old blood. The wound failed to heal, and a urinary fistula formed, about which ulceration occurred. Various types of local medication were used, but these had no influence on the spread of the ulcer. A cystostomy was performed in July. In August the patient received three injections of neoarsphenamine.

I saw the patient on September 25, at which time he presented an ulcer involving the dorsum of the penis from the corona to within ½ inch (1.3 cm.) of the base. This was about 1 inch (2.5 cm.) wide. The urethra was entirely destroyed, so that the corpora cavernosa were exposed and covered with a thick, tenacious exudate. The borders were purplish red and undermined. There was no adenopathy. The prostate was enlarged and soft.

Since then the process has gradually extended. Within the past ten days slight healing has been noticed at several points along the border.

Examination of the blood showed 93 per cent hemoglobin, 4,600,000 red blood cells, 8,400 white blood cells, 72 per cent polymorphonuclear leukocytes, 7 per cent monocytes and 21 per cent lymphocytes. Urinalysis showed no sugar, a trace of albumin, many pus cells and some bacteria. Culture of material from the lesion showed Staphylococcus haemolyticus and Bacillus coli. On histologic examination there was chronic and acute nonsyphilitic suppuration. Serologic changes were not present. A lumbar puncture gave negative results.

Treatment has consisted of local applications of potassium permanganate in soaks and wet dressings, diluted solution of sodium hypochlorite, zinc peroxide, methylrosaniline, 15 per cent urea in an ointment and in wet dressings, Krueger's autogenous antigen and dressings of iodoform powder and of iodoform in oil, 200 grains (12.96 Gm.) of potassium iodide daily by mouth for ten days, eighteen intramuscular injections of fuadin, autogenous antigen daily for the past six weeks and two intravenous injections of typhoid bacilli (temperature, 103.5 F.).

DISCUSSION

DR. H. J. TEMPLETON, Oakland, Calif.: I think it would be well to make an autoinoculation test for chancroid if that has not been done.

DR. C. E. SCHOFF, Sacramento, Calif.: If the condition is chancroid, I cannot see why a man with a lesion so extensive and of such long duration would not show lymphadenitis.

DR. E. A. LEVIN: Sometimes autoinoculation in chancroid infections causes ulcerations that are worse than the initial lesions. I suggest the use of Dmelcos vaccine (a stabilized suspension of Ducrey bacilli). The clinical appearance is somewhat suggestive of granuloma inguinale. I suggest further protein shock therapy with typhoid vaccine.

DR. F. G. NOVY JR., Oakland, Calif.: I do not think, from the man's history, that this lesion is chancroidal. It was never possible to find any Donovan bodies to support a diagnosis of granuloma inguinale. There was a little healing around the border after the first injection of typhoid bacilli. After another injection the healed area extended further. I have thought that continuing this treatment might be helpful.

Secondary Syphilis and Weil's Disease. Presented by the STAFF OF THE DEPARTMENT OF DERMATOLOGY, UNIVERSITY OF CALIFORNIA.

V., a Greek foundry worker aged 44, was first seen in the dermatologic clinic on Nov. 14, 1936. Eight weeks previously he had had a cold. Six weeks ago a lesion appeared lateral to the left nipple. This enlarged, became pustular and opened. Considerable swelling of the lymph nodes in the left axilla was noted. Two weeks before entry his friends told him that he was jaundiced. At this time he had pain in the right upper quadrant of the abdomen, accompanied with chills and general malaise. He has been a heavy drinker for many years.

Physical examination showed him to be icteric, with a generalized macular eruption involving the palms and soles, which was characteristic of secondary syphilis. There was an indurated lesion adjacent to the left nipple, which was typical of a syphilitic chancre. There were palpable axillary lymph nodes, more marked on the left side. The patient's liver and spleen were noticeably enlarged. He was hospitalized, and an intramuscular injection of 2 cc. of iodobismitol with saligenin was given on November 14. This treatment was repeated on November 17. During the interval the patient had a daily fever, which rose in the afternoon to 38.6 C. (101.5 F.). His urine, which at first contained a faint trace of albumin, on November 20 boiled solid when tested for albumin. That afternoon, after intravenous injection of 0.03 Gm. of mapharsen his temperature went up to 39.6 C. (103.3 F.), and an intensification of his eruption (Herxheimer) was noted. The next day and thereafter until December 4 his temperature remained normal. Laboratory examination revealed 4 plus Kahn and Kolmer reactions (said to have been negative a year before), and specimens of blood sent to Dr. K. F. Mayer at the Hooper Foundation demonstrated Leptospira icterohaemorrhagiae on repeated examination.

DISCUSSION

DR. FRANCIS TORREY: When this man was first seen the condition was thought to be frank secondary syphilis. Later, when Dr. Mayer was able to obtain Leptospira from his blood, it appeared certain that the man had two infections.

DR. H. E. MILLER: I was somewhat chagrined because I presented this man to the students as a patient with hepatitis and jaundice due to early syphilis. Later I was forced to admit that the jaundice was not due to the syphilis but to the coincident infection by Leptospira. The patient works in a warehouse where there are many rats.

DR. N. N. EPSTEIN: Apparently in infection by Leptospira similar lesions occur in both the kidneys and the liver, if judgment can be based on the intense albuminuria which developed.

DR. H. J. TEMPLETON, Oakland, Calif.: What is the treatment for Weil's disease?

DR. H. E. MILLER: I think convalescent serum is the only therapeutic agent of value. However, I believe the patients recover spontaneously.

Coccidioidal Granuloma. Presented by the STAFF OF THE DEPARTMENT OF DERMATOLOGY OF THE UNIVERSITY OF CALIFORNIA.

R., an Italian truck driver aged 40, was first seen on Oct. 10, 1934. At that time he had an eruption characterized by erythema and moderate edema on the left side of the face and the nose. It began three months before as a pimple which he scratched. The area involved was fairly sharply demarcated from the normal skin. The alae nasi were swollen, and the mucous membrane was crusted.

A biopsy specimen was taken on Dec. 10, 1934. The histologic picture was that of granuloma, and a parasite described as a double-contoured body with endospore formation, conforming to the description of Coccidioides immitis, was found in the tissue.

The patient worked as a truck driver in and around Salinas, Calif., and other parts of the San Joaquin valley between the ages of 17 and 40. Physical examination and laboratory analyses showed no abnormality at that time.

The patient disappeared and did not respond to various efforts made to locate him. He returned on Nov. 27, 1936. A brawny induration and erythema have developed and now involve almost the entire face. Cultures and smears were positive for Coccidioides immitis. Physical examination and laboratory analyses showed no abnormality.

A roentgenogram of the chest showed a peculiar fibrous streaking with a linear distribution which passed upward and downward from the right hilus and involved the middle and lower lobes of the right lung. There were adhesions which

obliterated the costophrenic and retrodiaphragmatic sulci on the right side. The left lung appeared normal. There was a compensatory emphysema of the upper lobe of the right lung. The interspaces of the ribs were abnormally narrow on both sides from the level of the third rib downward, which might be explained on the basis of a history of adhesive pleurisy. There was no evidence of cardiac enlargement. It was recommended that films be taken of the lower cervical and the upper thoracic sections of the spine, to be sure there was no osseous involvement.

DISCUSSION

DR. H. E. MILLER: The type of involvement in this case is unusual and interesting. The patient has chronic lymphangitis of the lip, the upper part of the nose and the cheeks. He does not have any subcutaneous abscesses—only a few papillomatous lesions due to long-continued passive congestion. His entire eruption could be accounted for by long-continued congestion. In an attempt to give something different in the way of treatment the man is being given a creosote preparation. A physician in Berkeley, Calif., reported a case in which the condition was cured with creosote. However, that is not the reason why we are giving creosote to this man. One investigator at the University of California Medical School has put sacks of coccidioides cultures in the peritoneal cavities of four rabbits. To two of the rabbits he gave creosote and used the other two as controls. He subsequently had a great deal of difficulty in growing the organisms on material from the rabbits who had been given creosote, whereas no difficulty was encountered in culturing organisms on material from the other two. The patient is being given calcium creosotate in the hope that he can tolerate larger amounts of this form than he could of straight creosote.

Rhinoscleroma with Diphtheria. Presented by the STAFF OF THE DEPARTMENT OF DERMATOLOGY OF THE UNIVERSITY OF CALIFORNIA.

G., a Central American man aged 26, was first seen in the University of California otolaryngologic clinic in May 1933. Both nares were filled with exuberant granulation tissue. A diagnosis of rhinoscleroma was made and confirmed by histologic examination in June 1933 and again in December 1934.

There is a history of an operation on the sinuses and a tonsillectomy seven years ago. The history is otherwise irrelevant.

Physical examination and laboratory analyses showed no abnormality in October 1935.

Roentgenographic study of the left side of the face on Nov. 7, 1935, showed the maxillary sinuses to be completely clouded and the trabeculae of the ethmoid cells to be completely destroyed on both sides. There were beginning clouding of the frontal sinuses and thickening of the mucosa of the sphenoid sinus. The turbinate processes were not seen. Atrophy of the bone and chronic thickening of the mucosa are characteristic of rhinoscleroma. A roentgenogram of the left side of the upper jaw showed an apical abscess of the left central incisor.

A histologic examination on Nov. 6, 1935, confirmed the diagnosis, showing acute and subacute inflammation in the stratified squamous epithelium and the subepithelial tissue. There was fibroblastic and endothelial proliferation. Mikulicz cells were scattered immediately beneath the epithelium, and there were a few in the subepithelial epithelium.

Smears and cultures at this time showed numerous diphtheroid bacilli and an encapsulated gram-negative bacillus closely allied to Friedländer's bacillus. The diphtheroid organisms were injected into a guinea-pig, which died in forty-eight hours. Autopsy showed diphtheria. Acid-fast stains gave negative results.

A centrally ulcerated tumor, about 2 cm. in diameter, then appeared on the left cheek about the level of the first molar.

In December 1935 smear and culture for diphtheria gave negative results. The patient was not seen from then until Nov. 11, 1936. The infection progressed in the interval. There is more involvement in the nasal mucosa, and a granuloma-

tous tumor mass is present at the inner canthus of the left eye. The sinus in the left nasolabial fold is larger, and there is more profuse drainage. Smear and culture on Nov. 6, 1936, showed no acid-fast organisms of diphtheria but some bacilli of the Friedländer group.

DISCUSSION

DR. CHARLES ALBERT SHUMATE: Dr. Harry E. Alderson, who is presenting a paper in Los Angeles on the first three cases of rhinoscleroma reported in California tonight, has had many letters and much material on rhinoscleroma from his former associate, Dr. Reyes of San Salvador. It is of interest that this patient is from the same country.

DR. H. J. TEMPLETON, Oakland, Calif.: It is interesting that rhinoscleroma, according to Dr. Reyes, is so frequent in San Salvador that it is looked on as rather commonplace.

A Case for Diagnosis. Presented by DR. E. D. CHIPMAN.

Miss G., a teacher aged 46, consulted me on Sept. 25, 1936, complaining of an eruption of eight or nine months' duration on the soles and the palms. She had been treated for a mycotic infection by several dermatologists. The lesions consisted of circumscribed areas of hyperkeratosis, interspersed, particularly between the toes, with fissures.

After two weeks' treatment with compound ointment of benzoic acid improvement was noted on the hands but not on the feet. Application of the ointment was continued on the hands and Castellani's stain (made from 25 parts saturated alcoholic solution of basic fuchsin, 58 parts 50 per cent alcohol, 1 part boric acid, 10 parts acetone and 6 parts cupric sulfate) was prescribed for the feet. Under this treatment the feet improved but the hands became worse. Next an ointment of salicylic acid, juniper tar and ammoniated mercury was advised for both hands and feet. After a short interval, improvement was noted on both hands and feet, but a new eruption, involving the trunk, the arms and the legs, appeared. This was diagnosed as pityriasis rosea, and it improved under an application of 2 per cent betanaphthol ointment. According to my notes, improvement was noted on November 5 and again on November 12. On November 23, however, the hands were worse, and on November 30 they were worse than at any time since the patient had been under my care. Does the contradictory response to treatment at different times suggest a revision of the diagnosis?

DISCUSSION

DR. F. G. NOVY JR., Oakland, Calif.: I believe this condition is stubborn chronic tinea of the hands and feet. At present the eruption on the body suggests dermatophytid more than pityriasis rosea.

DR. STUART C. WAY: This patient impresses me as having a monilial infection.

DR. H. E. MILLER: From what I saw of the hands and feet I thought the patient had dermatophytosis associated with dermatophytid. I think all the members have diagnosed conditions as pityriasis rosea and later have had to revise the diagnosis to dermatophytid.

DR. G. V. KULCHAR: I suggest a diagnosis of atypical psoriasis.

DR. E. D. CHIPMAN: I feel certain that the incidental eruption is pityriasis rosea, as it has shown a typical herald patch and other characteristic features. It seems to me that calling every lesion that occurs on the feet mycotic is a little wild. The pityriasiform lesions were promptly controlled by the application of 2 per cent betanaphthol ointment. I wish I might believe such treatment would control equally well all so-called dermatophytids. Dr. Kulchar's suggestion of atypical psoriasis seems to me most worthy of consideration.

Lupus Vulgaris. Presented by Dr. Charles Albert Shumate for Dr. Harry E. Alderson.

J. O., a German-born prospector aged 57, entered the clinic for dermatology and syphilis of the Stanford University Hospital on Oct. 31, 1936.

He presents extensive well circumscribed infiltrated red areas on his face, the right buttock and the groin. The external part of the left ear showed atrophic scarring and destruction. This process, he states, started twenty years ago.

In 1916 the patient claims to have had erysipelas of the face, the first cutaneous ailment he ever had. This cleared, but in 1923 he had a similar attack of erysipelas. In 1924 he presented a condition somewhat similar to the present one.

He entered the San Bernardino County Charity Hospital, at which institution he received about thirty-eight blistering light treatments with a quartz lamp. The patient states that it was after one of these treaments that his left ear became deformed and his left lower eyelid drawn down. His face gradually healed and remained clear until August 1936, when it became reddened, scaly and irritated again, presenting a clinical picture of lupus vulgaris.

The patient has a chronic cough, but complete examination of his chest revealed no pathologic changes.

The Wassermann reaction and the blood count showed no abnormality.

Sections were presented.

DISCUSSION

Dr. Charles Albert Shumate: Treatment with sodium gold thiosulfate has been instituted, and the patient has shown improvement. Are there any suggestions for any other treatment for this patient?

Dr. H. J. Templeton, Oakland, Calif.: How about a Gerson-Hermannsdorfer diet?

Dr. G. V. Kulchar: I think the involution under gold therapy has been most striking in this case. A salt-free diet and administration of tuberculin were considered, but gold therapy was decided on.

Dr. Stuart C. Way: Originally gold therapy was used in lupus vulgaris, but its greatest efficiency seems to be in early lupus erythematosus.

Leukoplakia Buccalis. Presented by Dr. J. M. Graves.

L. R. Taussig, M.D., *President*

Feb. 26, 1937

John M. Graves, M.D., *Secretary*

Nodulo-Ulcerative Syphilis. Presented by Dr. A. E. Ingels.

C. H., a white woman aged 70, a housekeeper, entered the Stanford University Hospitals on Dec. 15, 1936, because of irregular nodulo-ulcerative lesions and areas of infiltration and scar formation on both sides of the face, the neck and the upper part of the sternum. These manifestations appeared suddenly seven years ago, with fever and painful swelling of the neck from ear to ear. The patient was confined to bed for one week. Under treatment with hot fomentations the lesions subsided without ulceration or discharge. Since then acute exacerbations of nodular swellings have alternated with quiescent periods. Some of the nodules have broken down and migrated, leaving healed scarred areas. In some areas the scars are keloidal and show contractures producing indentations or pockets resembling sebaceous cysts. The ulcers were painless. Three weeks before the patient was first seen she burned the radial side of the dorsum of her right wrist. At this site a deeply infiltrated brownish red area with a suggestive semicircular outline, altogether about 8 cm. in diameter, developed. It did not ulcerate.

The patient has been strong and healthy all her life. She had "varicose ulcers" twenty-five years ago. She never menstruated, was never pregnant and stated that to her knowledge she had never had a venereal disease.

The Wassermann and the Kahn reaction were strongly positive. Microscopic examination showed no acid-fast organisms, amebas, blastomycetes or Coccidioides immitis. The picture presented was compatible with that of syphilis.

The patient was given bismuth therapy, and the lesions have now healed completely, only scarring remaining.

The case is presented as an example of long-standing syphilis in which almost any form of granuloma would have been a possible diagnosis.

DISCUSSION

(All members agreed with the diagnosis.)

A Case for Diagnosis (Papular Eruption of the Cheek). Presented by Dr. Merlin Trevor-Roper Maynard, San Jose, Calif.

R. P., a youth aged 18, a student, is presented because of an eruption of one month's duration on the left cheek below the eye. The lesions appeared simultaneously. Recently new areas have appeared laterally, near the ear. The lesions are brownish scaly papules, the color shading off into that of the normal surrounding tissue. On diascopic pressure some follicular abscess formation is evident. The lesions are symptomless.

There is no personal or family history of tuberculosis. The patient had measles in infancy. He does not catch colds easily and has no cough. The physical examination of his chest showed no abnormality. A tuberculin test one year ago gave negative results. The blood count was normal. The Wassermann reaction was negative.

Diagnoses of lupus vulgaris, lupus erythematosus and rosacea-like tuberculid have been considered.

DISCUSSION

Dr. Howard Morrow: I do not see anything about the condition that is suggestive of rosacea-like tuberculid. The diagnosis of lupus erythematosus must be ruled out.

Dr. C. J. Lunsford, Oakland, Calif.: I think this condition might well be lupus erythematosus.

Dr. Merlin Trevor-Roper Maynard, San Jose, Calif.: At first I felt the condition was rather suggestive of lupus vulgaris. Careful examination, however, made me consider rosacea-like tuberculid of Lewandowsky. Some of the characteristics of this condition are: 1. It is rarely exclusively in the center of the face, and the forehead and the chin are favorite locations. 2. There is little sebaceous activity. 3. Demodex folliculorum is rare or absent. 4. The lesions are papules, pustules and follicular brownish nodules, which appear on diascopic pressure. This boy's lesions show follicular pustulation, and they are brownish. There are two lesions which at a glance resemble lupus erythematosus.

Atrophia Maculosa et Striata. Presented by Dr. Francis Torrey.

W., a white youth aged 18, was first seen in the dermatologic clinic of the University of California on Jan. 19, 1937. He presents numerous linear transverse bands of atrophic white and purplish blue skin, varying from 0.5 to 2 cm. in width and from 2 to 10 cm. in length. They run principally transversely over the lower posterior part of the chest and the upper part of the back. There are a few lesions about the anterior axillary fold.

He was referred from the department of thoracic surgery, where he has been under treatment for chronic empyema, which began after pneumonia in February 1936. Streptococcus was the infecting organism, and there was associated pericarditis.

The patient first noticed the striae when recovering from resection of a rib in May 1936.

DISCUSSION

DR. H. J. TEMPLETON, Oakland, Calif.: I have never seen any condition like this before. It strikes me as being akin to the atrophic striae seen in pregnant women and in persons who become obese suddenly and then lose weight.

DR. L. R. TAUSSIG: This type of lesion occurs in pregnancy, in obesity followed by loss of weight, in a long-standing febrile disease, such as typhus, and as an incident to growth between the ages of 16 and 20. In the last two connections the striations are apt to occur on the lower portion of the back. In this boy they occurred at the proper age to belong to the fourth classification. The patient has also undergone a long-drawn-out febrile disease. In Arzt and Zieler's textbook on dermatology there is a photograph of a condition similar to this one.

DR. G. V. KULCHAR: This condition has been described in basal cell adenoma of the pituitary glands. This patient has, however, no other signs of pituitary dystrophy.

DR. ERNEST K. STRATTON: The patient's history of carrying bundles of newspapers weighing 100 pounds (37 Kg.) on his back between the ages of 12 and 14 years suggested to me a traumatic cause for the condition. The bands were found when he was on the operating table, but they are in such a location that they may have been present before this without his knowledge.

DR. FRANCIS TORREY: Both the patient's prolonged illness and his unusually rapid growth are probable causative factors.

A Case for Diagnosis (Lupus Erythematosus?). Presented by DR. C. J. LUNSFORD, Oakland, Calif.

W. F. B., a white woman aged 48, was first seen on Sept. 6, 1936, in consultation. On the forehead and between the shoulders there was a v-shaped area of acute itching papular dermatitis, with some scaling. There was a mild erythematous eruption in the occipital part of the scalp, accompanied with some dandruff. This was said to have begun after a severe sunburn in May 1936. The patient had had a life-long mild intolerance for sunshine. She had been taking various hypnotics during the last several weeks before I first saw her. I advised her physician to stop the administration of drugs, to search for foci of infection and to use a 5 per cent solution of ammoniated mercury on her scalp and a 1 per cent dilution of solution of coal tar N. F. in a shake liniment on the glabrous skin. I saw her again on Dec. 7, 1936, after her physician had been using irradiation from the air-cooled quartz mercury vapor arc. The lesions were then more diffuse and acute. Similar lesions had developed on the forearms and the chest. The patient looked and felt sick. A diagnosis of a toxic eruption, probably acute lupus erythematosus, was made.

Complete rest was suggested, and wet dressings of boric acid solution and other soothing local applications, a heavy vitamin intake and autohemotherapy were employed until Jan. 22, 1937. The acute activity of the lesions by that time had subsided. The general condition of the patient had greatly improved.

During the last month at weekly intervals the local lesions have received ⅛ skin unit of roentgen radiation with benefit. On the right scapula, the right forearm and the left upper quadrant of the chest there are subacute, indurated and scaly erythematous lesions, which have some of the characteristics of lupus erythematosus. The case is presented for diagnosis.

The blood count on Dec. 7, 1936, showed 4,440,000 erythrocytes, 80 per cent hemoglobin, 5,475 leukocytes, 48 per cent polymorphonuclears, 45 per cent small monocytes, 7 per cent large monocytes and 177,000 platelets. On Dec. 8, 1936, there were 5,700 leukocytes and 188,000 platelets.

DISCUSSION

DR. HARRY E. ALDERSON: A biopsy probably would help in the diagnosis. It is rather significant that the woman has been sensitive to sunlight for a long time. It is hard to explain the bizarre form of some of the lesions localized on one side. The condition could be lupus erythematosus.

DR. N. N. EPSTEIN: It suggests lupus erythematosus to me.

DR. MERLIN TREVOR-ROPER MAYNARD, San Jose, Calif.: Some features of the eruption suggest lichen planus. However, it does look like lupus erythematosus.

DR. C. J. LUNSFORD, Oakland, Calif.: Some of the considerations favoring a diagnosis of lupus erythematosus are: (1) the woman's general condition, (2) her history of sensitivity to sunshine, (3) the aggravation of the lesions following irradiation from the air-cooled quartz mercury vapor arc by another physician and (4) their involutions under treatment by protection, rest in bed and absence of sunshine. There has been little itching.

Syringocystadenoma. Presented by DR. H. J. TEMPLETON, Oakland, Calif.

R. S., a white nurse aged 42, has noticed lesions on the neck and the face for the last three years. These are small flesh-colored papules or flat plaques varying in size from that of a pinhead to that of a pea. They are so inconspicuous that they can be seen to best advantage only when the light strikes them at the proper angle.

Microscopically, strands of basal cells are seen in the corium.

DISCUSSION

DR. HOWARD MORROW: Eruptions like this usually occur in women and are nearly always on the eyelids or over the zygoma; it is rather difficult to obtain a biopsy specimen. I am in the habit of making a clinical diagnosis in cases like this. I often ask for a biopsy specimen; the patient asks if removal of a specimen will leave a scar, and I have to answer that it will and that the result of the biopsy will not affect the treatment.

I do not think the indications of the microscopic specimen in this instance are sufficient for a diagnosis of syringoma.

Therapy is most unsatisfactory because effective treatment produces scars.

DR. L. R. TAUSSIG: I think that clinically this case is one of syringocystadenoma. I agree with what Dr. Morrow has said about treatment. The lesions are rather insignificant, and any destructive treatment is apt to cause scars. Sufficient roentgen radiation to destroy the lesions would undoubtedly lead to late sequelae.

DR. G. V. KULCHAR: I suggest the diagnosis of epithelioma adenoides cysticum. The lesions were not as yellowish as those usually seen in syringocystadenoma.

DR. HARRY E. ALDERSON: I have been using an isobutane—$(CH_3)_2.CH.CH_3$—spray for this condition. It leaves the skin perfectly clear. Two months ago I saw a man whose whole forehead was involved. The lesions cleared beautifully after exfoliation.

DR. A. E. INGELS: I should like to support Dr. Templeton in his diagnosis. Microscopically, I see no features of epithelioma adenoides cysticum; on the contrary, loose epithelial strands with a suggestive lumen are seen. I have always felt, however, as have many pathologists, that conditions like this should be classified as different varieties of the same disease.

DR. H. J. TEMPLETON, Oakland Calif.: I feel that there are enough of these comet-shaped groups of cells to justify the diagnosis of syringoma.

Recurrent Plantar Warts. Presented by DR. H. J. TEMPLETON, Oakland, Calif.

K., a woman aged 30, is presented for discussion as to further therapy of a plantar wart, which has recurred in spite of various types of treatment.

The following treatment has been given: On March 29, 1935, a plantar wart, 0.75 by 1.5 cm., was treated conservatively with 4 skin units of unfiltered roentgen radiation. On April 26, 2 skin units of unfiltered roentgen radiation was applied. On August 6, the wart was still present. For several weeks it was treated by paring and the application of plasters treated with 25 per cent salicylic acid. From March 24 to June 4, 1936, the patient received weekly injections of a suspension of metallic bismuth. There was no improvement. On July 6, 1936, the wart was excised with generous areas of surrounding normal skin, and the wound was sutured. On July 30, 1936, the condition appeared to be cured. By Aug. 14, 1936, recurrence was noticeable in two tiny areas in the scar. These lesions were destroyed with actual cautery. On Oct. 8, 1936, two more small warts in the scar were cauterized. On Nov. 10, 1936, the entire area was curetted deeply and widely and pure silver nitrate stick was applied. Recurrence was evident on Dec. 10, 1936.

The case is presented for suggestions for further therapy and for an opinion as to whether, in view of the fact that the entire area previously irradiated has been excised, application of radium is permissible.

DISCUSSION

Dr. Harry E. Alderson: Such cases are always more or less embarrassing. No matter what the physician does, the condition recurs. I have frequently called in an orthopedist. I notice that this woman's transverse arch is flat. There may be an internal traumatic factor, although the papillomas are back of the heads of the metatarsal bones.

Dr. C. J. Lunsford, Oakland, Calif.: In a somewhat similar involvement a couple of years ago, a surgeon finally excised the lesion and did a pedicle graft. Nice healing occurred and to date there has been no recurrence.

Dr. Merlin Trevor-Roper Maynard, San Jose, Calif.: My experience with this type of plantar wart has been that it will not respond to irradiation. The warts may disappear temporarily, but recurrences are common. I have seen some of them disappear after injections of a bismuth preparation. With some I have given bismuth for several weeks prior to irradiation. It may be that the lesion gets a secondary irradiation from the bismuth deposit at its base. I am rather chary in employing radium because of its deeper effects and prefer daily applications of a local caustic—dichloroacetic acid, for example—in such cases. If the patient can stand the pain of the procedure, a complete cure is usually obtained by this method.

Dr. Ernest K. Stratton: Dr. Templeton asked me for suggestions as to therapy. In cases in which I have obtained good results I have excised the wart first and then given roentgen radiation immediately afterward.

Dr. L. R. Taussig: In view of the fact that the patient had 6 skin units (approximately 1,800 r) over that area, I do not consider it safe to give further radiation, even though the affected tissue was subsequently excised.

Dr. H. J. Templeton, Oakland, Calif.: All the members have had difficult problems, such as the one this case presents. Various suggestions have been given to me tonight, some of which I shall try. I shall try Dr. Torrey's suggestion of the use of an ointment of procaine hydrochloride and formaldehyde, and Dr. Maynard's suggestion appeals to me. The patient has been urging me to try irradiation again, but I have refused to do so. I have not had the successful results that many have reported from irradiation. I have given doses varying from 6 skin units in small areas to 3 skin units in larger areas. Without accurate statistics, I should say that my results have fallen far short of the 72 per cent of cures reported by the Mayo Clinic.

A Case for Diagnosis (Superficial Scaling Eruption of the Trunk). Presented by The Staff of the Dermatologic Clinic of the E. V. Cowell Memorial Hospital, Berkeley, Calif.

A. B., a youth aged 20, presents an eruption on the upper part of the trunk of one year's duration. The eruption is ragged, dirty grayish, scaling and retiform;

it is maximal on the sternum and fades gradually over the lateral wall of the chest, leaving little to be seen on the back. There is no erythema or infiltration beneath the scaling. There are no associated symptoms. The patient states that the eruption was less noticeable last summer, while his trunk was frequently exposed to sunlight. The patient's general health is excellent. On two separate occasions scales from the lesions were examined for fungi, with negative results.

DISCUSSION

DR. G. V. KULCHAR: I think the diagnosis of poikiloderma will have to be entertained although there is not much vascular change. The other diagnosis to be considered would be one of the idiopathic atrophies, but there is too much pigmentation for that, I think.

DR. H. J. TEMPLETON, Oakland, Calif.: Because of the scaly lesions, I am inclined to think this condition is a reticular type of parapsoriasis.

DR. L. R. TAUSSIG: I do not see any atrophy. The lesions present superficial scaliness and pigmentation. I do not see how one could consider this case one of poikiloderma of Jacobi. The eruption in poikiloderma is prominent, and one does not have to put the patient in a good light in order to discern the lesions. At a glance I thought this condition resembled tinea versicolor. Tentatively I should entertain the diagnosis of parapsoriasis.

DR. H. V. ALLINGTON: I believe that the total lack of erythema makes the diagnosis of parapsoriasis unlikely. I considered the possibility of a variety of seborrheid.

DR. C. J. LUNSFORD, Oakland, Calif.: Dr. Templeton applied a preparation of sulfur, salicylic acid and Peruvian balsam. The lesions were not influenced by that therapy. I agree that there is no atrophy in the lesions. I think there is more evidence of parapsoriasis than of any other condition.

Phagedena Secondary to Periurethral Abscess. Presented by DR. F. G. NOVY JR., Oakland, Calif.

A. B., a white man aged 28, was presented before this society at the December 1936 meeting (ARCH. DERMAT. & SYPH. **36**:1238 [Dec.] 1937). Since that time the process has extended, particularly at the base of the penis. There has been some tendency to healing along the right side.

The patient has received eight intravenous injections of typhoid vaccine and twelve injections of staphylococcus toxoid, neither having produced any apparent improvement. Prostatic massage twice a week has produced some diminution of the discharge about the base of the penis. Recently I thought that irrigation through the wound made by suprapubic cystotomy might do some good.

Several direct and dark field examinations have been made since the patient was last presented. These showed nothing notable. Repeated cultures of the secretions have shown only Bacillus coli and staphylococci.

DISCUSSION

DR. H. J. TEMPLETON, Oakland, Calif.: What about the depth of these lesions? Are there any deep sinuses or fistulas? Does the infection go through into the bladder?

DR. F. G. NOVY JR., Oakland, Calif.: There is an infection in the bladder. I do not know, however, that there is a direct extension into the bladder.

DR. H. J. TEMPLETON, Oakland, Calif.: What do you think of maggot therapy?

DR. C. J. LUNSFORD, Oakland, Calif.: The patient's condition is definitely improved. Why do you not just carry on with what you have been doing?

DR. G. V. KULCHAR: The urologists widely excise such growths with a diathermy knife. Medication with antimony and potassium tartrate has also been used.

DR. F. G. NOVY JR., Oakland, Calif.: In cases which have come under my observation and in which the cautery has been used the condition has always recurred.

DR. H. V. ALLINGTON: It seems to me that if the same type of infection is present in the prostate, all local treatment may be futile until that infection is cleared. The major treatment may have to be directed to the infection higher up.

Morphea. Presented by DR. N. N. EPSTEIN and DR. E. A. LEVIN.

This patient, a white woman aged 54, presents on the right flank a dollar-sized patch of whitish, somewhat atrophic skin, the center of which is covered with a small crust. The lower border of the area feels indurated. The patch has been present for thirty-five years.

General examination reveals an obese woman suffering from dysfunction of the thyroid and of the pituitary gland.

The blood count was normal. Urinalysis showed no abnormality, and the Wassermann reaction was negative. The basal metabolic rate was —8 per cent.

Microscopic examination of the indurated area shower an atrophic epithelium, blunting and obliteration of the rete pegs and absence of the sudoral and sebaceous glands in the corium. The collagen fibers were large and thickened and in portions suggested hyalinization. No calcium deposits were noted. A mild inflammatory reaction, consisting of small foci of lymphocytes, was present.

Morphea. Presented by DR. N. N. EPSTEIN and DR. E. A. LEVIN.

This patient, a white man aged 28 years, was first seen on Sept. 22, 1936, when he presented an asymptomatic palm-sized infiltrated faint bluish patch on the upper left part of the back. It had been present for nine months.

Microscopic examination showed nothing specific but was suggestive of sclerodermatous change.

The patient was given a total of 375 r of unfiltered roentgen radiation in four doses between Sept. 25 and Oct. 30, 1936. No change was noted by Nov. 20, 1936. On Dec. 11, 1936, a diagnosis of sarcoid was suggested, and the patient was given 5 drops of solution of potassium arsenite three times a day. On Jan. 22, 1937, the process was definitely receding, and there was less infiltration. On Feb. 19, 1937, the lesion was noticeably smaller.

Microscopic examination of the indurated area on Feb. 19, 1937, showed an atrophic epithelium. The corium consisted chiefly of a large number of thickened collagenous fibers. Some edema and a moderately inflammatory reaction consisting of focal areas of lymphocytes, mostly perivascular, were present.

The blood count was normal. Urinalysis showed no abnormality, and the Wassermann reaction was negative.

DISCUSSION

DR. L. R. TAUSSIG: I had the opportunity of seeing this boy with the lesion on his shoulder previously. I thought that the most likely clinical diagnosis was sarcoid. Dr. Epstein brought the biopsy material to the University of California Medical School for sectioning. The first specimen was superficial, and Dr. Epstein and I thought at first that it was not satisfactory for diagnosis because he had not gone deep enough. The second specimen was taken deeply enough, and the pathologic picture was compatible with a diagnosis of scleroderma and was not suggestive of sarcoid. When I saw the patient this evening, I was even more satisfied than previously with the diagnosis of scleroderma.

DR. HOWARD MORROW: Dr. Miller saw this patient at the same time that I did. He and I could not decide between sarcoid and scleroderma. I have since heard about the biopsies and I accept the diagnosis of scleroderma.

DR. N. N. EPSTEIN: Of these two patients, the young man presents the more interesting picture. After Dr. Miller saw him he made the suggestion that the patient be given arsenic or solution of potassium arsenite. Up to that time I could see no perceptible change in the lesion. When a biopsy specimen was removed from the lesion it was difficult to cut through it. The solution of potassium arsenite has definitely reduced this lesion. A second biopsy specimen was removed recently

without much difficulty. I think that the condition pathologically is scleroderma. We considered one of the blastomas in the differential diagnosis.

I do not think any further therapy is indicated at present, as long as the lesions seem to be undergoing involution to some extent.

The woman's case is interesting because the picture is more that of morphea. The ulceration of the lesion is of interest.

DR. G. V. KULCHAR: Another form of therapy which has been used with some success is the prescription of a ketogenic diet and the production of acidosis by large doses of ammonium chloride. That method was advocated by Lariche, of Strasbourg, France.

DR. L. R. TAUSSIG: I am not sure that any treatment is effective. In the literature all sorts of therapy have been suggested. From Budapest, Hungary, Sellei reported good results with extracts of the stomach and of the pancreas. It seems to me that any reports of the cure of scleroderma must be accepted with reservations.

DR. A. E. INGELS: I have seen generalized scleroderma improve considerably under fever therapy. Have any of the members had any experience with that treatment?

DR. N. N. EPSTEIN: I have not observed any cases in which generalized scleroderma has been treated in that way.

DR. R. OSTWALD (by invitation): It has been said that disturbances in metabolism may predispose a patient to scleroderma. Perhaps the woman presented might be helped by preparations of thyroid or something of that kind.

NEW YORK ACADEMY OF MEDICINE, SECTION OF DERMATOLOGY AND SYPHILIS

J. GARDNER HOPKINS, M.D., *Chairman*

Feb. 2, 1937

DAVID BLOOM, M.D., *Secretary*

Pityriasis Rubra Pilaris. Presented by DR. MAX SCHEER.

R. G., a boy aged 10 years, complained of an eruption of eight months' duration.

On each leg there are a half-dozen sharply defined round or oval erythematous patches, from ½ to 2 inches (1.3 to 5 cm.) in diameter. The patches consist of discrete, closely set, follicular papules, topped with a dry horny scale. In some of the smaller patches there is somewhat less erythema around the papules, so that the papules stand out more clearly. There are no follicular papules on the fingers. The finger-nails are pitted, curved and slightly thickened.

DISCUSSION

DR. HOWARD FOX: I disagree emphatically with the diagnosis of pityriasis rubra pilaris. In this case there are sharply bordered acuminate papules on a reddish background, while in pityriasis rubra pilaris the papules are surrounded by normal skin and are not grouped in patches. The condition lacks other features of that disease, such as the thickening of the palms and the soles, which is almost pathognomonic.

DR. MAX SCHEER: I admit, of course, that some of the features are absent. If they were all present and this condition were absolutely characteristic, I should not have presented the patient here. There are diseases with polymorphous manifestations, in which for a time only one lesion is present. I think there is only

one manifestation here at the present time. It is true that the disease begins with isolated keratotic papules, but the papules fuse and form red patches. I have seen the condition in children before. I recall that some years ago Dr. Abramowitz presented a case of pityriasis rubra pilaris in a child.

Achromia Parasitica. Presented by DR. MAX SCHEER.

R. B., a boy aged 4 years, has an eruption of one year's duration. The lesions are located on both forearms. There is an oval scaly red lesion on the left forearm, the size of a dime. On the extensor surface of each forearm are about a half-dozen round or oval achromic spots, from ¼ to ¾ inch (0.6 to 1.9 cm.) in diameter. In these spots there is no redness or scaling, but scrapings from them showed fungi when stained with potassium hydroxide. No cultures were made.

DISCUSSION

DR. J. GARDNER HOPKINS: I am sure I have seen depigmented lesions in children exposed to the sun, in which fungi could not be demonstrated. My associates and I attributed these to seborrhea. In Pardo-Castello's cases he demonstrated various fungi. I think Dr. Beatrice Kesten found Hormodendrum in most of her cases in Puerto Rico. The conditions described by Pardo-Castello were of a little different clinical type than this one and were not due to ringworm. I do not know if in those cases it was possible to find the organisms in smears or only on culture.

DR. MAX SCHEER: Most of the cases that have been described have involved Negro children. This patient is white. My associates and I found fungi in the lesions but did not attempt to determine from the scrapings the type of fungus present.

A Case for Diagnosis (Purpura Annularis Telangiectodes?). Presented by DR. MAX SCHEER.

F. R., a man aged 30, born in Italy, a mason, has an eruption of seven years' duration. The lesions are located on the ankles and the thighs, and in the groin, the axillae and the flexures of the elbows. They appear as discrete small purpuric spots, which enlarge and become pigmented. They are round or oval and show no atrophy. Some have entirely disappeared; others (especially on the ankles) are said to be of one or two years' duration. The outbreak of a new lesion is accompanied by slight itching.

Physical examination showed no abnormality. The Wassermann reaction was negative. Examination of the blood showed 80 per cent hemoglobin, 4,650,000 red blood cells and 7,600 white blood cells; the differential count showed 50 per cent segmented and 5 per cent nonsegmented polymorphonuclear leukocytes, 38 per cent lymphocytes and 7 per cent monocytes. The bleeding time was two and one-half minutes and the coagulation time seven minutes; the tourniquet test gave negative results. The sedimentation time was over three hours. The fragility test showed the following results: in solutions of sodium chloride of from 0.72 to 0.53 per cent, no hemolysis, from 0.48 to 0.36 per cent, partial hemolysis, and 0.32 per cent, no hemolysis.

The report by Dr. Samuel M. Peck of the histologic examination of a biopsy specimen was as follows: "The epidermal changes are not important. There is some hyperkeratosis and no atrophy. There is a fairly massive inflammatory exudate occupying the papillary and subpapillary bodies. There one sees a good deal of free hemorrhage and dilated capillaries, in places forming what might be called varicosities. Around such vessels, perivascular infiltration of lymphocytes with some polymorphonuclear leukocytes is seen. The deeper vessels are dilated and engorged. In some instances the walls of the vessels are thickened. Where the free hemorrhage occurs it seems to do so by diapedesis. Diagnosis: The histologic picture could fit in with an early lesion of Majocchi's purpura."

There is no mention of the presence or absence of hyaline degeneration of the walls of the vessels.

DISCUSSION

DR. SAMUEL M. PECK: The more I study cases like this, the more apparent becomes almost hopeless confusion in both the clinical and the histologic concepts of this disease. In angioma serpiginosum there are lesions which clinically resemble purpura but histologically do not; in Schamberg's or Majocchi's disease the histologic picture is that of purpura, but it is often impossible clinically to differentiate the lesions from angioma serpiginosum. It is apparent that the grouping of these diseases needs revision and further study. It will do no good just to report one or two cases in an attempt to cast more light on this group of diseases. If one studies the histologic reports in cases from this group, especially in those in which more than one biopsy has been made, it is not unusual to find histologic pictures even in one case which resemble any one of the other conditions.

DR. LOUIS TULIPAN: Such cases are observed frequently. The condition is simple purpura, associated with some type of infection. I was recently able to clear up a condition of that type by demonstrating in a nephritic patient that every time she "went off on a food spree" she got an outbreak of the eruption, which receded as soon as she stopped.

DR. OSCAR L. LEVIN: I agree with the diagnosis made by Dr. Scheer. If the members present could observe the lesions by daylight, as I had the opportunity to do, the condition would be recognized readily as Majocchi's disease. It was probably difficult to make out the fine details in the light in which they were viewed this evening. The lesions are those of telangiectatic vessels, showing the tendency to ring formation, and there are evidences of atrophy in the central portion of some of the patches. It is not definitely known what the cause may be. However, it is my opinion that the presence of this condition depends on the presence of a toxic agent which affects the smaller vessels of the skin. I believe not only that the small vessels are affected but that the large vessels of the body may be involved. Several years ago I reported a case of purpura annularis telangiectodes of the skin in which it was discovered at autopsy that the abdominal aorta contained an aneurysm. It may be worth while to examine all patients with Majocchi's disease for the possible detection of foci of infection or the presence of some disease which may be producing an irritant to the blood vessels.

DR. MAX SCHEER: I presented the case for diagnosis. I thought my diagnosis was about as accurate as could be made clinically. The histologic studies were neither for nor against the diagnosis, but I notice that there is no hyaline degeneration of the vascular walls. That is a feature which Dr. George M. MacKee stressed as being pathognomonic histologically for purpura annularis telangiectodes. I agree with the other speakers that the whole concept of this disease is rather hazy and not clearcut from that of some other conditions.

Idiopathic Multiple Hemorrhagic Sarcoma of Kaposi. Presented by DR. CHARLES WOLF.

J. C., a married man aged 49, born in Puerto Rico, is presented because of an eruption of nine years' duration, located on the feet, the legs, the thighs, the trunk and the upper extremities. The patient states that a discoloration first appeared on the outer side of the right foot about nine years ago. Two years later a bluish discoloration appeared on the left foot. The lesions then spread to the back of the right knee and finally appeared on the trunk and the upper extremities. None of the lesions have itched.

On the inner and the outer side of each foot there is a diffuse bluish red infiltration. On the back of the right knee there are several bluish nodular lesions. On the trunk and the upper extremities there are slight elevations, which on palpation feel firm. These lesions have no discoloration but are best seen at a tangential plane.

Biopsy specimens have been taken from the foot, the left scapular region and the chest. Histologic examination of the tissue removed from the foot was reported

as showing Kaposi's sarcoma and that from the scapular region as showing "possible leukemid." The third specimen, which was nonpigmented, showed a picture strongly suggestive of Kaposi's sarcoma. Examination of the blood showed 84 per cent hemoglobin, 5,100,000 red blood cells, 9,000 white blood cells and 230,000 platelets. The differential count showed 46 per cent polymorphonuclear leukocytes, 36 per cent lymphocytes, 8 per cent monocytes, 3 per cent segmented cells and 7 per cent eosinophils. The Wassermann reaction was negative.

DISCUSSION

DR. SAMUEL M. PECK: This case is of great interest, because there are a number of unusual features. No one, I think, could have made the diagnosis of Kaposi's disease from the skin-colored lesions which the patient presents. Such skin-colored lesions gradually develop into typical bluish red nodules, which then bring to mind the correct diagnosis. Histologic examination of the lesions from the foot showed typical Kaposi's sarcoma, with angiomatous formation, proliferation of adventitial cells and hemorrhage. The histologic picture presented by the skin-colored lesions is that of a mild inflammatory process. The importance of the case lies in the lesions which do not show the typical picture of Kaposi's disease. Review of those skin-colored lesions which were previously called chronic inflammations reveals a type of vessels closely resembling those in the fully developed lesion of Kaposi. The study of cases such as this may give the members help in the recognition of atypical Kaposi's sarcoma.

DR. SIGMUND POLLITZER: I want to comment on one unusual feature in this case, the absence of pigmentation. You will recall that the name originally proposed by Kaposi was idiopathic, multiple, pigmented sarcoma. Pigmentation is absent in these lesions, which otherwise conform to the picture of sarcoma of Kaposi.

DR. SAMUEL M. PECK: Studies of the blood were made by Dr. Nathan Rosenthal because of the original diagnosis of leukemid. The only abnormality was the presence of 8 per cent eosinophils.

DR. ISADORE ROSEN: This is one of the most unusual instances of Kaposi's sarcoma that I have ever observed, unusual because of a generalized dissemination of the lesions. One would hardly suspect the presence of this disease from the lesions on the trunk.

Thrombo-Angiitis Obliterans and Multiple Telangiectases. Presented by DR. OSCAR L. LEVIN.

S. P., a man aged 60, first noticed persistent red spots on the face at the age of 40. During the past twenty years similar lesions have appeared on other areas of the face, the scalp, the lips and the mucous membranes of the mouth. There has never been any bleeding from the skin, the mouth or the nose.

About seventeen years ago ulcers developed on the tips of the second and third fingers of the left hand. Following an injury to the left foot, eleven years ago, a persistent ulcer developed and healed only after the patient had made a prolonged stay at the Hospital for Joint Diseases. Four years before presentation he was admitted to the Mount Sinai Hospital for treatment of thrombo-angiitis obliterans and an ulcer of the left foot, which measured 4 by 6 inches (10 by 15 cm.). The ulcer healed, and the general condition improved as a result of intravenous administration of numerous doses of solution of sodium chloride. About six weeks ago the patient appeared at the clinic, complaining of intense pain in the right middle finger and a small ulcer under the nail.

Since his discharge from the hospital in 1934 he has been under constant supervision and treatment in the clinics for treatment of cutaneous diseases and of thromboangiitis obliterans of the outpatient department. His main complaints have been pruritus, deformities of the finger-tips and red spots on the face. At times he has complained of headaches, dizziness, shortness of breath, an occasional cough and swelling and edema of the legs.

The skin shows the presence of telangiectases on the face, the scalp, the neck, the buccal mucosa, the tongue and the lips. The vessels are grouped to form dark red and purplish patches that vary in size from that of a small pea to that of a small bean. The face is cyanotic, and the skin of the hands and the feet is swollen and purplish and feels cold. Both radial arteries are open, but the ulnar arteries are closed. The fingers are shortened and show partial destruction of the nails. The spleen is enlarged, and the liver is palpable below the free border of the ribs. The blood pressure is 130 systolic and 90 diastolic. The Wassermann reaction was negative. The roentgenogram of the chest revealed the presence of old scars and healed tuberculosis of the lungs. The eyes showed corneal opacities, but there was no evidence of angiomas of the eyegrounds. The otologist reported that there were changes in the labyrinth, which may have been caused by changes in the blood vessels similar to those in other parts of the body.

Examination of the blood showed 9,600 white cells and 4,880,000 red cells. The differential count showed no abnormality. There was 70 per cent hemoglobin.

DISCUSSION

DR. LOUIS TULIPAN: The picture appears to me typical of sclerodactylia. The skin is atrophied and adherent to the bone, and there is tapering at the terminal ends of the phalanges, which is not the picture seen in thrombo-angiitis obliterans.

DR. SAMUEL M. PECK: In my opinion the telangiectatic lesions have nothing to do with the thrombo-angiitis obliterans. The peculiar tightness of the skin, which almost suggests scleroderma-like changes, certainly fits in with that diagnosis. Such trophic disturbances are not unusual in patients with poor vascularity of the extremities. The telangiectasia is like the hereditary familial form. However, this patient gives no familial history of the condition and does not complain of nasal bleeding. This disease consists of a nevus with bleeding because of the localization of telangiectasia in the mucosa, where they are easily traumatized and are not protected by the horny layer of the skin. In other words, I think the condition is typical of thrombo-angiitis obliterans with trophic disturbances of the skin and a nevus which is characterized by telangiectasia.

DR. OSCAR L. LEVIN: The diagnosis was confirmed by Dr. Samuel Silbert, who has had unusually wide experience in the diagnosis and treatment of this disease. The more detailed history is characteristic, and all the characteristic clinical signs are present. Some of the additional symptoms are aches and pains, coming on especially after exercise or any other form of muscular exertion, changes observed in palpation of the vessels, cyanosis of the extremities, blanching of the legs on elevation and increased cyanosis of the legs when hanging down, as over the side of a table.

The other conditions which are suggested are Raynaud's disease and sclerodactylia. Against the condition's being Raynaud's disease is the fact that the characteristic history and sequence of symptoms are absent. There is no history of a vasomotor disturbance. Ischemia has not been present, and there is no evidence of pallor and blanching on exposure to cold. As to sclerodactylia, that condition may be readily ruled out, because there is absolutely no evidence of scleroderma anywhere. The fingers and the toes do not show the infiltration of scleroderma. There is no atrophy or tightening of the skin by contractures involving the function of the digits. All that is present is cyanosis due to interference with the circulation of the blood through the peripheral vessels. The deformities of the tips of the fingers and the toes have resulted from ulcers following trauma. The ulcers healed, leaving the evidences of scarring. There is no mutilation such as occurs in sclerodactylia.

My purpose in presenting this patient was to show thrombo-angiitis obliterans associated with possible small changes in the finer blood vessels, as in the skin, the mucous membranes and the ears. It is always best to try to show a relation between a cutaneous condition and a constitutional disease. It is interesting to note that the otologists were of the opinion that the changes in the ears were

similar to those occurring in other parts of the body. This opinion was made without any suggestion from the dermatologic department. There is no history or evidence that the telangiectasia is congenital or familial. It was not present at birth and was never noticed until the patient was 40 years old.

Pachyonychia Congenita. Presented by DR. A. W. GRACE.

J. P., a schoolboy aged 9 years, was first seen in December 1936. At 2 years of age he had had measles, complicated by pneumonia. During convalescence an eruption arose all over the body in the form of small pustules, occurring at first singly and then in crops, and finally coalescing to form thin-walled bullae filled with seropurulent material. At the same time the finger-nails and toe-nails became markedly thickened. During the past seven years the condition has persisted, with the bullous lesions healing in places and arising in new sites; the nails have been frequently shed. In October 1936 hyperkeratotic lesions were first noted on the buttocks, the extremities and the back. The family history was noncontributory.

On examination the upper lip, just below the nares, shows a small crusted superficial lesion resembling impetigo contagiosa. On the dorsum of the right foot is a collapsed bulla about 2 cm. in diameter, with a base and a small surrounding zone of erythema. All the nails are greatly thickened, and some show perionychial inflammation. Practically the whole surface of the skin, with the exception of the scalp, the palms and the soles, is the site of follicular hyperkeratosis. On the borders of the natal cleft and on the tips of the elbows the hyperkeratosis is particularly well marked, forming warty masses, some as large as a match head. The larger lesions are slightly hemorrhagic as a result of scratching. The tongue is covered on its dorsal and lateral aspects with a whitish "fur" which cannot be scraped off, and similar elevated areas are present on the hard palate and the buccal mucosa, opposite the dental line on both sides of the mouth. The patient is pale and appears chronically ill.

Histologic examination of a hyperkeratotic area of skin showed follicular dipping down of the horny layer, which was much thickened. Between the keratin plugs the skin was somewhat atrophic and the cornification not so marked. In a few places at the bottom of such plugs there was a degenerating layer of cells belonging to the stratum granulosum, the granules of which were swollen and deep staining and lay about loose in the degenerating tissue, resembling the "grains" of Darier's disease. *Corps ronds* were not seen. Serial sections were not examined.

The results of complete physical examination and of the Kline test, a blood count, urinalysis, determinations of cholesterol and urea nitrogen in the blood, measurement of the basal metabolic rate, culture of stools, and mycologic examination of lesions on the feet were noncontributory. Treatment consisted of application of ammoniated mercury ointment to the bullous lesions.

DISCUSSION

DR. E. B. TAUBER, Cincinnati (by invitation): I agree with the diagnosis. The patient shows the characteristic symptoms originally reported by Jadassohn and described in a later case under different terminology by Cole and Dower. He shows the condition of the tongue, which has a thrushlike appearance, the cutaneous lesions and the lesions of the nails. I have a patient, 20 years old, who has a similar condition, and in a case of such long duration the nails are usually completely absent. The condition in this type of case will pass at times as possible epidermolysis bullosa and at times as some other congenital condition. There will have been some roentgen therapy and sometimes application of ointments, possibly with improvement at times. The cutaneous lesions, curiously, seem at times to improve spontaneously. There is an apparent loss of immunity to pyodermic conditions. Patients with this condition complain that every little trauma irritates them. They are practically in the condition of persons with epidermolysis bullosa.

Proceeding along lines suggested by these observations, empirically and inductively, I discovered that there was absence of cystine. Dr. Louis A. Brunsting, of the Mayo Clinic, has been using cystine in the treatment of other conditions. I used injections of cystine for my patient, and complete amelioration of the cutaneous manifestations followed. The nails were gone, but the cutaneous condition cleared up, and the mucous membranes are now smoother and less aggravated than they have been in the past ten or twelve years.

DR. A. W. GRACE: I shall carry out what Dr. Tauber suggested in regard to therapy in this case. It is probable that therapy by replacement of sulfur was suggested by the work done on pellagra some time ago. It was found that patients with pellagra lost a good deal of sulfur through shedding of the nails. Since then the giving of sulfur has been found to be of some benefit in treating pellagra. It is possible that this boy is losing a good deal of sulfur from his economy by the falling off of these large nails from time to time.

Dyshormonal Dermatosis (Werner's Syndrome). (Scleroderma, Poikiloderma, Bilateral Juvenile Cataract, Precocious Graying of the Hair, Pluriglandular Dysfunction.) Presented by DR. MARION B. SULZBERGER.

D. G., a man aged 44, born in the United States, is the brother of the patient A. G., to be presented here tonight.

The illness began at the age of 6 years with the discovery of high grade myopia. At the age of 12 years graying of the hair appeared. At 18 the patient suffered from gonorrhea, and at 22 there was completely gray hair and progressive alopecia. At 28 years bilateral periarterial sympathectomy was performed on both femoral arteries (no details of which are available). At 29 extensive cellulitis developed on the left foot, with subsequent development of numerous ulcerations on both feet. At 36 blindness suddenly developed within six months, and vision was restored after successful removal of cataracts. The patient has indulged freely in alcohol and tobacco. The libido and potency are claimed to be normal.

Family History.—Both the grandparents and the parents were first cousins. The patient's father died at the age of 83 of diabetic gangrene. The mother had graying hair at an early age and has bilateral cataracts. There is an extensive family history of premature graying of the hair. The patient's brother has a similar condition. Eight other siblings died during childhood.

The patient is mentally rather subnormal and has a defective memory. The chest and the trunk are well developed; the extremities are small; the bony prominences are exaggerated. There is advanced baldness, with graying of the remaining hair. The eyes have both been operated on for cataracts. The teeth are in fair condition. The patient's voice is remarkably highly pitched. His blood pressure is 134 systolic and 95 diastolic. The external genitalia and testes are small. There are sclerodermatous changes on the distal parts of all the extremities and poikilodermatous changes over the knees. There is definite hyperkeratosis of the soles, and numerous scars from old ulcerations are visible on the feet. There are other patches of hyperkeratosis over the olecranal processes. The skin of the face is thickened and roughened.

Laboratory Data.—The blood count was normal except for slight lymphocytosis. The urinalysis showed no abnormality. Chemical analysis of the blood showed 13 mg. of urea nitrogen and 89 mg. of dextrose per hundred cubic centimeters. The dextrose tolerance test showed results of 85, 94, 95, 95 and 88 mg. per hundred cubic centimeters, and the calcium determination, 10.5, 10.5, 11, 10.5 and 10.2 mg. per hundred cubic centimeters. The calcium balance was within normal limits. The phosphorus determination gave results of 4.1, 3.5, 3.8 and 4 mg. per hundred cubic centimeters. The basal metabolic rate ranged between +4 and —15 per cent.

Histologic examination revealed changes characteristic of scleroderma and poikiloderma. Roentgenograms demonstrated linear calcifications in the soft parts of the calves. Several phalanges and parts of the metatarsal bones were missing.

There were slight arthritic changes in the upper extremities and slight calcifications of the arteries of the pelvis and both thighs. The sella turcica was normal in shape and size. There was no absorption of bone.

This case has been previously presented at the Section of Medicine of the New York Academy of Medicine by Drs. B. S. Oppenheimer and V. H. Kugel (Tr. A. Am. Physicians **49**:358, 1934).

Dyshormonal Dermatosis (Werner's Syndrome). Presented by DR. MARION B. SULZBERGER.

A. G., a man aged 38, born in the United States, is the brother of the patient D. G., just presented.

At the age of 8 years graying of the hair appeared. At 20 years the patient began to lose his hair. At 22 he was markedly bald, and at 29, two weeks after a trivial injury to the left eye, he became partially blind. Bilateral cataracts were found. A first stage operation on the cataract on the left side was followed by restoration of vision. At 33 years the patient was completely blind on the right side; vision was restored after a first stage cataract operation. At 34 years there was a blister on the right foot. This led to cellulitis, to coma and to the discovery of diabetes. The further developments included polydipsia, polyuria and polyphagia. There was a subsequent loss in weight of 43 pounds (19.5 Kg.), and numerous ulcers appeared on both feet. (For the family history, see the report of the case of his brother, D. G.)

The mentality and the psyche are normal. The extremities are small. There are advanced baldness and graying of the remaining hair. The eyes both protrude markedly and present evidences of the operations for cataracts. All the teeth are missing (due to absorption of bone). The chest is emphysematous. There is enlargement of the heart, and a systolic murmur is heard over the precordium. The liver can be palpated 4 fingerbreadths below the costal edge, while the spleen cannot be felt. The external genitalia and testes are small. The blood pressure is 120 systolic and 85 diastolic. No pulses can be felt on the lower parts of the legs and the feet. The radial and ulnar arteries are thickened. There is ankylosis of the right knee (due to injury).

The skin presents atrophic changes, as well as smoothness and shininess on the lower parts of both legs, on both feet and to a lesser degree on both forearms. There are marked telangiectases over both knees and indolent ulcerations on both feet.

Laboratory Data.—The blood count was normal except for a slight lymphocytosis. Urinalysis showed no abnormality. Chemical analysis of the blood showed 10.9 mg. of urea nitrogen and from 106 to 220 mg. of dextrose per hundred cubic centimeters. The dextrose tolerance test showed results of 153, 164, 163, 192, 217, 236 and 155 mg. per hundred cubic centimeters, and the calcium determination, 10.9, 10.6, 11.9, 13.0 mg. per hundred cubic centimeters. The calcium balance was definitely negative. The phosphorus determination gave results of 3.7, 2.5 and 3.7 mg. per hundred cubic centimeters. The protein content of the serum was 6.9 Gm. per hundred cubic centimeters, and the albumin content, 3 Gm. per hundred cubic centimeters. The basal metabolic rate ranged from —6 to —24 per cent.

Histologic examinations revealed changes characteristic of scleroderma or poikiloderma. Roentgenograms demonstrated marked calcification of the vessels of both hands, of the lower extremities and of the pelvis. There was decalcification of various bones, and there were arthritic changes in various joints. The sella turcica was normal.

DISCUSSION

DR. MARION B. SULZBERGER: When Professor Bruno Bloch was here, he read a paper on dyshormonal dermatoses before the American Dermatological Association. This contribution was published by Bloch and Stauffer (ARCH. DERMAT. & SYPH. **19**:22 [Jan.] 1929). Two cases were described, one in a man and one in a woman. Dr. Peck and I both saw the patients in Zurich. When I first made

rounds at the Montefiore Hospital for Chronic Diseases here and saw one of these patients, I thought it was the man I had known in Zurich or at least his identical twin. The entire appearance and the facies were so similar that it was obvious by simple inspection that this man at Montefiore was suffering from the same complaint as had my friend Honegger in Zurich. The cutaneous lesions resemble most closely those seen in poikiloderma, associated with some cutaneous changes seen in scleroderma. The interesting point is the association with other internal manifestations and glandular "dyscrasia." These patients have juvenile cataracts in one or both eyes. In all four cases which I have observed there have been cataracts. There is also hypogenitalism. The men have small testicles and the women practically no ovaries or uterus. The patients are sterile and are inclined to adiposity. Bloch's female patient was of the masculine type, whereas men with the disease have gynecomastia, a distribution of fat and hair of female type, hairless faces and high-pitched voices. In addition to that, it is interesting to note that one of these brothers has marked diabetes. I believe these cases tonight are the only ones which have been reported in two brothers. It would seem that the condition is familial and perhaps based on some disturbance primarily localized in the anterior lobe of the pituitary gland. In one of these cases there is diabetes, which may be attributable to the lack of pancreatropic hormone of the pituitary. It is therefore possible to postulate that the gonadotropic, the adenotropic (which regulates fat metabolism) and the pancreatropic hormone (in one case at least) are not functioning or being elaborated in a normal fashion. The cutaneous changes are not entirely identical with those seen in typical basophilic adenoma of the pituitary. There is, for example, no hypertrichosis.

I am greatly indebted to Dr. Rudolf Baer, of the dermatologic service, and to the members of the medical division at the Montefiore Hospital for Chronic Disease for working the cases up and bringing the patients here this evening.

Dr. Eugene F. Traub: I should like to ask a question about the vascular changes in these two cases, as well as the atrophy about the knees. The vascular changes seem to consist of the formation of new blood vessels.

Dr. J. Gardner Hopkins: I was interested in the changes which seemed like those of poikiloderma of Jacobi. It seemed to me that muscular atrophy was marked and more than might be expected as secondary to the cutaneous changes. Is that a feature of this condition? Did the woman mentioned by Dr. Sulzberger show the adiposity and hirsuties described by Cushing in his cases of basophilic adenoma of the pituitary? In Cushing's cases there was involvement of the pancreas in one, of the gonads in another and of the thyroid in another. The pluriglandular features of the basophilic adenoma of the pituitary would fit this condition. I should like to know on what grounds that condition has been ruled out.

Dr. Marion B. Sulzberger: As far as Dr. Traub's question is concerned, these changes in the blood vessels are considered to be those which are often seen in poikiloderma—that is, dilatation of the superficial blood vessels and probably some atrophy of the skin, which makes the dilated vessels more visible. The cutaneous lesions over the knees really look like sequelae of roentgen irradiation. There are atrophy, dilatation of the blood vessels and some scattered hyperpigmentation and depigmentation. These cutaneous changes are probably an essential part of the syndrome, as they were present in both the other patients I have seen. As far as the muscular atrophy is concerned, I do not know if there is any real muscular atrophy. In my experience patients with this condition all have this pudgy appearance, and they are not active. I think their muscular tonus is probably altered in conjunction with other trophic changes. I have not seen any histologic sections of the muscles. How to differentiate the condition from basophilic adenoma of the pituitary I do not know, but I know that these two particular cases have been studied carefully by all the excellent internists and neurologists of the Montefiore Hospital for Chronic Diseases with that in mind and the condition has never been diagnosed as the basophilic syndrome. Perhaps, nevertheless, some basophilic adenoma of the pituitary or of the other glands would be found

if the patients should come to autopsy. As for Dr. Hopkins' question, the woman in Zurich had no hypertrichosis. In fact, there was little hair. In addition, she was obese but had poorly developed breasts, no ovaries and no palpable uterus. It is astonishing how closely these cases simulate one another. From the dermatologic point of view they surely suggest a relation to cases of so-called congenital ectodermal defect.

Dr. R. Baer (by invitation): All I can add is that the sella turcica has been studied carefully in both cases and that no changes have been found. I do not know whether there were any other indications for a diagnosis of basophilic adenoma of the pituitary. Some interesting facts not yet mentioned were that the grandparents of these brothers were first cousins, that the father suffered from diabetes and the mother had premature graying of the hair and bilateral juvenile cataracts and that there are in the patient's family several other cases of premature graying of the hair.

A Case for Diagnosis (Pseudo Acanthosis Nigricans?). Presented by Dr. E. William Abramowitz.

Mrs. A. K., a woman aged 55, presents an eruption of three years' duration, located under the breasts, in the axilla and in the groins. This appeared three years ago, first under the breasts in the form of brown pigmentation, then in the axillae and finally in the groins and the anal and popliteal regions. With the exception of the groins, these pigmented areas presented some small papules and in the popliteal areas some reticulation. In the groins there were raised granulomatous, ulcerated lesions appearing in the form of irregular linear streaks.

The patient gave a history of having almost suffocated with fumes from an oil-burning stove in February 1936. In April she had a "measles-like" rash on the legs and the arms. In the fall she took pills for constipation. (These pills were known as "casca royal" [Blackburn]. They contained calcium sulfide, capsicum, atropine (belladonna extract) and a trace of castor oil. They did not contain phenolphthalein. They were previously called "castor oil pills.") Her general health is good. She has been at the St. Mary's Hospital, Passaic, N. J., where the pathologist stated that she had mycosis fungoides.

Several Wassermann and Kahn tests were negative. The histologic report on a specimen from the lesion of the groin pointed to possible secondary syphilis; that on a specimen from the pigmented lesion in the axilla pointed to ordinary dermatitis. A complete blood count showed no abnormality.

DISCUSSION

Dr. E. William Abramowitz: The appearance of the skin gave me the impression that I might be dealing with an early and unusual type of acanthosis nigricans. There is a similar case reported in the literature under the title of pseudo acanthosis nigricans. It may be that the patient had been using some external applications, and the eruption may have been produced by that means. It has no resemblance in any way to a plenolphthalein eruption. She has had no roentgen therapy.

Melanodermatitis Toxica (Hoffmann). Presented by Dr. Richard James Kelly.

J. A., a woman aged 33, born in Russia, was first seen two months ago, at which time she complained of an eruption on the forearms and the dorsa of the feet. The eruption has been present for eight months. It consists of diffuse small lichenified lesions of reticular appearance and shows grayish brown pigmentation. Occasionally there is slight scaling. On the dorsa of the feet are scattered follicular papules almost the color of normal skin. The eruption is more pronounced on the right forearm than on the left and is almost entirely limited to the extensor surfaces. The patient is a machine operator but claims that she has not been in close contact with machine oil.

Histologic examination showed marked hyperkeratosis. This seemed definitely localized. The granular layer was wide, particularly below those portions where the hyperkeratosis was most marked. The epidermis appeared atrophic. A distinct degeneration had occurred in the basal layer. Where this had occurred, the melanin had disappeared, but chromatophores were conspicuous in the upper portion of the cutis, and there was a well defined superficial zone of edema and mononuclear infiltration. The picture was suggestive of lichen planus, but obviously certain differences were present. This, along with the clinical picture, appeared to place the condition in the group of melanodermatitis. The histologic diagnosis was melanodermatitis toxica lichenoides (et bullosa) of Hoffmann (melanosis of Riehl).

A Case for Diagnosis (Pityriasis Rubra Pilaris?). Presented by DR. HENRY D. NILES.

E. F., a woman aged 49, has had a generalized eruption for the past twenty-seven years. This started after the birth of her first child as erythematous patches on her cheeks and rapidly spread to the rest of her body. At first there were considerable edema and fissuring, but the eruption later became dry and red and was accompanied with much desquamation. The patient has had little perspiration since the onset of the eruption, and during the hot weather she is compelled to remain indoors because of the discomfort caused by heat. During three subsequent pregnancies she was much improved, but the eruption never entirely disappeared. She received thyroid extract and many topical remedies, without improvement.

The skin of the entire body except the inframammary regions is involved. The eruption is characterized by erythema, scaling and follicular hyperkeratoses, especially over the dorsal surfaces of the hands and the wrists. In some areas, especially on the flexor surfaces of the arms and forearms, the skin is thin and shiny, and there are many tiny umbilicated lichenoid papules. The skin of the entire face is dry, red, thickened and scaly. There are no lesions in the mouth. There is scaling of the scalp, the palms and the soles. General physical examination showed no abnormality except obesity and mild hypertension.

Laboratory Reports.—Urinalysis showed no abnormality. The basal metabolic rate was —2 per cent. The Wassermann and Kahn tests were negative. Histologic examination of a section from the dorsum of one wrist showed a slightly parakeratotic epidermis with a slight increase of the granular layer in a few places. There was fairly regular acanthosis, with elongated and clubbed rete pegs. The lymphatic and the blood vessels in the upper part of the cutis were dilated and surrounded by an infiltrate of round cells. There was moderate interstitial and parenchymatous edema. The histologic diagnosis was a superficial exudative inflammatory reaction, suggestive of disseminated neurodermatitis in a subsidiary stage.

DISCUSSION

DR. J. FRANK FRASER: I cannot make a diagnosis of pityriasis rubra pilaris from a microscopic study of the sections. In regard to the anhidrosis, the sweat glands showed no pathologic alterations. The clinical picture favors the diagnosis of pityriasis rubra pilaris.

DR. ISADORE ROSEN: In view of the fact that the results of histologic examination rule out pityriasis rubra pilaris, I suggest the diagnosis of erythroderma congenitale ichthyosiforme.

DR. E. WILLIAM ABRAMOWITZ: This is the same impression I received. Essentially the patient has erythroderma with some scaling. I admit the individual lesions are small, almost follicular. It is surprising that with this ichthyosiform eruption the condition should be worse in summer than in winter.

DR. EUGENE F. TRAUB: On the contrary, I thought the appearance of the face was exactly that which I have seen in a number of cases of advanced pityriasis rubra pilaris. Often this type of facial change goes on until the patient has marked

ectropion and ocular damage. I believe the changes on the face and the scalp, together with the follicular plugging on the backs of the hands, the appearance of the palms and the soles and the lesions resembling lichen planus on the forearms, with the keratotic lesions on the back, constitute a fairly typical picture of pityriasis rubra pilaris in one phase of the disease.

DR. HENRY D. NILES: Clinically, I should like to present this case as one of pityriasis rubra pilaris. The reason I do not is that the histologic report in no way bears out that diagnosis. The appearance of the histologic section is compatible with a picture of neurodermatitis. The patient is a little better now than she would be without treatment. An interesting feature is the absence of perspiration, which makes her uncomfortable in the summer. She has been pregnant five times and each time has shown distinct improvement. These are the only times she has ever improved, in spite of all kinds of treatment. She is now approaching the menopause. I am particularly interested in suggestions for possible endocrine therapy because of that history. I have discussed this with several gynecologists, and they have suggested the use of gonadotropic substance from the urine of pregnant women and of other endocrine products on that basis. She has been given thyroid, to no avail.

A Case for Diagnosis (Blue Nevus? Argyria?). Presented by DR. VAN ALSTYNE H. CORNELL.

J. G., a woman aged 28, is presented because of a discoloration on the right side of her face. She was first seen a week ago. The patient states that at the age of 16 she noticed a bluish discoloration of the sclera, which has become gradually worse in the succeeding twelve years. For the past three years she has noticed a bluish discoloration on the forehead and below the eye. She gives a history of an accident in which her right eye was struck. This happened just before the onset of the discoloration. There is no history of silver medication, externally or internally.

Under both eyes, especially the right one, and on the right side of the forehead, there is bluish black pigmentation of the skin. There are bluish black patches on the right eyeball.

Examination of the skull showed the sella turcica to be somewhat ovoid and a shade low in its ventrodorsal diameter, yet within the 10 per cent limit of normal variation. It was smooth, with no discernible evidence of erosions or pressure atrophy. Examination of the skull showed no other abnormality. Examination of the chest showed the mark of an old thoracotomy at the level of the eighth rib, with synostosis between the seventh and the eighth rib and pleural thickening along the right lower part of the thoracic wall; there was no other abnormality. Examination of the eye showed a bluish discoloration of the sclera of the right eye and of the skin of the infra-orbital region on the same side. There was slight pigmentation of the area between the outer angle of the right eyebrow and the margin of the hair, measuring 7 cm. in its horizontal diameter. Tension was normal to the fingers. The pupillary reflexes were normal, as were the muscles and the fundi.

DISCUSSION

DR. E. WILLIAM ABRAMOWITZ: The patient denies ever having used any organic silver compound. The unilateral distribution of the lesion, involving the scleras and the outer surfaces of the eyelids and extending up to the scalp, makes me think the condition is probably blue nevus. My colleagues and I are considering a biopsy for the dopa reaction and, if necessary, the employment of Stillians' test with potassium ferrocyanide and sodium thiosulfate for determining the presence of argyria.

DR. HENRY D. NILES: One objection to the diagnosis of nevus is that the condition is not unilateral. There was bluish discoloration of the other eye. There was a sort of ring around the pupil, somewhat like an arcus senilis.

DR. E. B. TAUBER, Cincinnati (by invitation): I rather concurred in the diagnosis of blue nevus. I think there is a way of possibly differentiating blue nevus from argyria. I do not recall the details of the method of Stillians but I believe sodium thiosulfate and potassium ferrocyanide are used to decolorize the lesion. A nevus will not be affected, but if the lesion is argyria it will be decolorized.

DR. VAN ALSTYNE H. CORNELL: Some of the members of the staff at the hospital suggested that this case might be one of blue nevus, such as Tièche described in 1906. In his cases the pigmentation was bluish or bluish black and was seen mostly on the face; it always occurred at birth. In his description of the pigment cells, he stated that some of them have a positive dopa reaction and some of them do not. They are supposed to be similar to the pigmented cells in the mongolian spot.

A Case for Diagnosis (Sarcoid? Tuberculoid Type of Leprosy?). Presented by DR. EUGENE F. T. KELLEY, Yonkers, N. Y.

E. C., a Negress aged 32, born in the British West Indies, is presented because of an eruption on the arms, the buttocks and the face of two years' duration. The patient was first seen on Dec. 12, 1936.

On the right nostril there is a soft flesh-colored nodule the size of a split pea. There is a split papule on the right oral commissure; a few grouped pinhead-sized flat papular lesions on both upper eyelids; subcutaneous nodules the size of a lima bean, with erythematous overlying skin on the arms and the buttocks and depigmented areas of skin of the same size. A group of enlarged lymph nodes are palpable in the submental area. The ulnar nerves are palpable. The fingers are slightly swollen. There are no areas of anesthesia present.

Repeated nasal smears were examined for Hansen's bacillus, both before and after ingestion of potassium iodide, with negative results. The Wassermann reaction was negative. Intradermal tests with tuberculin, in dilutions of 1:100,000 and 1:10,000 gave negative results. Roentgenograms of the chest showed bilateral pulmonary tuberculosis. Roentgenograms of both hands showed large vascular foramina of the phalanges (sarcoid).

Histologic examination of a superficial lesion showed a typical sarcoid structure. The specimen from a subcutaneous nodule showed changes too indefinite for histologic diagnosis. Sections from both biopsy specimens stained with the Ziehl-Neelsen stain showed no organisms.

DISCUSSION

DR. DAVID BLOOM: Except for the enlargement of the ulnar nerves, this condition has all the features of generalized cutaneous tuberculosis in the Negro. The tiny papules on the eyelids, the nodules at the right ala nasi and on the vermilion border of the lips and the osseous and pulmonary changes have been described repeatedly as present in this type of tuberculosis.

DR. EUGENE F. T. KELLEY, Yonkers, N. Y.: This patient presents two types of lesions, which differ clinically and histologically. She has definite tuberculosis, yet leprosy cannot be ruled out.

Pustular Psoriasis. Presented by DR. GEORGE M. LEWIS.

M. S., a woman aged 22, complains of a condition which developed seven months ago. The scalp and the extensor surfaces of the elbows and the knees show typical patches of psoriasis. On both palms are scaly well defined erythematous patches the size of a 50 cent piece and studded with numerous deeply set small pustules. The microscopic examination did not reveal any fungi, and cultures gave negative results. Cutaneous tests with trichophytin and oidiomycin showed negative reactions. The Wassermann reaction was negative. A section of skin from the palm showed the typical changes of pustular psoriasis.

DISCUSSION

DR. DAVID BLOOM: Usually no typical psoriatic lesions are seen in association with pustular psoriasis of the palms and the soles. It is gratifying to observe this case, for it should change the opinion of those who doubt the justification of the name pustular psoriasis for palmar and plantar lesions.

DR. J. GARDNER HOPKINS: I cannot help wondering whether if that lesion on the elbow had been on any other part of the body it would have been so readily called psoriasis. Dermatologists frequently see similar lesions in bacterids. I think the combination of the two types of lesions is extremely interesting. The real test would be to find the focus of infection in this case and see what would happen if it was removed.

DR. GEORGE M. LEWIS: This patient presents typical lesions on the scalp, the elbows and other parts of the body, as well as pustular, erythematous plaques on the palms and on one heel. I think this is a cleancut instance of pustular psoriasis in a patient with psoriasis vulgaris.

Epidermolysis Bullosa (Dystrophic Type). Presented by DR. LESLIE PAXTON BARKER.

C. G., an Italian boy aged 14, is presented because of an eruption which has been present since birth. The patient was born with several blisters on the body, and these have recurred following slight trauma and even spontaneously. The blisters occur on any part of the body, including the mouth, the palms and the soles. The finger-nails and toe-nails were shed when the patient was 3 days old and have not regrown. The first set of teeth became carious and fell out early. The second teeth are soft and break off during eating. When the oral blisters occur, the mouth is sore, and the patient is unable to ingest anything except fluids, and even fluids cause discomfort. The tongue cannot be protruded. The patient has a poor appetite and eats little because of the discomfort. There is no familial history of cutaneous diseases.

General physical examination shows an emaciated and undernourished boy. The tonsils are large and cryptic. The spleen is palpable. Otherwise, the physical examination shows no abnormality except the eruption. There are drying bullae and crusted lesions on the trunk and the extremities, most marked over the trunk, where they range from the size of a small split pea to that of a half-dollar. Most of the lesions are discrete. Some are apparently hemorrhagic and are interspersed with areas of pigmentation from old lesions. On the extremities they are most numerous over the extensor surfaces, especially about the joints. The skin over most of the trunk and the extremities is thin, atrophic and wrinkled, that condition being most marked over the extensor surfaces of the forearms, the hands and the feet, where the skin resembles tissue paper and is bluish red. A few milium-like bodies are present on the dorsa of the hands. The finger-nails and toe-nails have been replaced by scar tissue, and the last three toes on each foot are adherent because of scar tissue. The teeth are carious, and many are broken off. The gums are puffy and bleed easily. There are several erosions on the mucosa of the cheeks, especially along the line of closure of the teeth. The tongue is bound down to the floor of the mouth. It has no frenulum and cannot be protruded. Along its sides and tip are several erosions and milk-white spots. The hair on the scalp is abundant, and the skin of the face is apparently normal.

Urinalysis showed no abnormality. The Wassermann reaction was negative. The protein content of the serum and the urea content of the blood were normal. Roentgen examination of the chest showed no abnormality. The blood count showed 4,200,000 red blood cells, 73 per cent hemoglobin and 11,000 white blood cells, with 63 per cent polymorphonuclear leukocytes, 29 per cent small lymphocytes, 1 per cent large lymphocytes, 4 per cent monuclear leukocytes and 3 per cent eosinophils.

The patient has been given intramuscular injections of liver and a high vitamin diet. He has felt much better and now has a good appetite.

The basal metabolic rate was —16 per cent.

DISCUSSION

DR. E. WILLIAM ABRAMOWITZ: Have any histologic studies been made of the elastic tissue in this case?

DR. J. GARDNER HOPKINS: There occurs some question as to how much can be included under the dystrophic type of epidermolysis bullosa. Should one call this type of condition epidermolysis bullosa or epidermal defect? With the oral lesions, the changes in the teeth and so on, I think that, whatever one calls it, the conditions described under these two names are possibly different degrees of the same congenital defect.

DR. LESLIE PAXTON BARKER: I believe all the changes this patient presents can be ascribed to epidermolysis bullosa, with the possible exception of those of the teeth, which are probably the result of a secondary nutritional deficiency. The teeth are friable, and dentition is poor. This may be due to avitaminosis, as the patient has had an inadequate diet because of discomfort in eating. Tobias reported a case in 1928 in which the patient had a friable first set of teeth; in the second dentition the teeth were irregular and widely spaced.

A Case for Diagnosis (Granuloma Inguinale?). Presented by DR. E. WILLIAM ABRAMOWITZ.

W. C., a Negro aged 60, was born in Florida but has resided in the north for the past ten years. He contracted syphilis four years ago, and he has received antisyphilitic treatment for the past two years. Last October a penile lesion about the size of a 25 cent piece appeared on the prepuce. It showed a granulating elevated surface with a rolled border and was indurated. Two months later adenitis developed in the left groin, suppurated and broke through one week ago. At present one sees the original lesion, much smaller and with several new lesions on the edge of the foreskin.

The Wassermann reaction is now 1 plus. The Dmelcos test (with Ducrey bacilli) gave doubtful results. Histologic examination of a biopsy specimen taken from the large lesion on the prepuce indicated possible granuloma inguinale.

With permanganate dressings the original lesion has improved considerably. The question is whether this lesion is atypical granuloma inguinale, nonspecific ulceration or chancroid.

DISCUSSION

DR. SAMUEL M. PECK: The clinical course of the lesion in this patient apparently speaks against the diagnosis of granuloma inguinale. One of the cardinal signs of this disease is the lack of glandular involvement. Histologically the only characteristic feature is the presence of the histiocytes containing Donovan bodies. Otherwise, the changes are those seen in any chronic inflammation of long standing. I would say that this patient probably is not suffering from granuloma inguinale.

DR. MARION B. SULZBERGER: I think this case is one of chancroid with a broken-down bubo, the edge of which has been infected as well. The positive reaction to the Dmelcos test is fairly corroborative. Granuloma inguinale could not account for the entire picture here presented, for, as far as I know, it never affects the deep lymphatic vessels. I think the fact that there has been spontaneous involution of the penile lesion speaks somewhat for the diagnosis of soft chancre.

DR. LOUIS TULIPAN: In addition to all the statements made by Drs. Sulzberger and Peck, with which I agree, results of following up a number of cases of chancroid at the Bellevue Hospital show this much: that many granulomas on the genitals, sometimes unaccompanied with inguinal adenopathy, have been proved to be chancroids. The patients have positive reactions to the Dmelcos test; besides

that, auto-inoculation of them has produced ulcers which yielded the Ducrey bacillus. When iodoform powder is applied, the lesions clear up quickly. I am sure this condition will be found to be chancroid.

DR. A. W. GRACE: There is one thing about this patient that has not been stressed much so far, and that is that four years ago he had a lesion on the penis which led to purulent adenitis in the same groin. Had that earlier lesion been chancroid or lymphogranuloma venereum, the value of the Dmelcos or the Frei test now would be dubious. I am not sure whether a person can get chancroid more than once or whether he can be reinfected within a period of a few years after the termination of the original attack.

DR. T. J. RIORDAN: I should like to supplement Dr. Tulipan's report. I have listened here for the past ten years to discussion of the difficulty of culturing the Ducrey bacillus. Today Dr. William Director, Dr. Tulipan's associate, showed me cultures in human blood and slides demonstrating the chainlike bacilli of Ducrey. As he pointed out, there is nothing to see in the culture—no pellicle—but on taking material from the liquefied area, he was able to find the bacilli.

Tattoo Dermatitis (Sensitivity to Cinnabar?). Presented by DR. MARION B. SULZBERGER.

A. C., a man aged 25, had been tattooed on the upper part of the right arm in red and blue in the summer of 1934. Two months ago he first noticed that the red tatooed areas became elevated. There were no subjective manifestations at any time.

The patient now presents a red and blue tattooed design, in which the blue markings have remained flat and normal, while all the red portions are elevated about ⅛ inch (0.3 cm.) above the surrounding skin, as if embossed.

NOTE.—Since the presentation, this patient has been found to have positive eczematous responses to patch tests with ammoniated mercury ointment U. S. P., mercury bichloride in water (1:1,000) and cinnabar (applied as powder). A patch test with 10 per cent precipitated sulfur in petrolatum gave negative results.

Report on a Case Previously Presented for Diagnosis (Bromoderma?). DR. A. W. GRACE.

D. F., a woman aged 41, was presented before this section on Jan. 5, 1937 (ARCH. DERMAT. & SYPH. **36:** 885 [Oct.] 1937).

The patient refused to allow a biopsy specimen to be taken. The Wassermann reaction was negative. She used calamine lotion for three days and nothing at all for the next seven days, and then returned to the clinic. At the last visit the lesion had practically disappeared and was represented by a faint erythematous blush. Therefore, it is felt that the diagnosis of bromoderma was established in this case.

Report on a Case Previously Presented for Diagnosis. DR. J. FRANK FRASER.

G. C., a man aged 54, was presented by Dr. Anthony C. Cipollaro before this section on Jan. 5, 1937 (ARCH. DERMAT. & SYPH. **36:**879 [Oct.] 1937).

The histologic picture was typical of mycosis fungoides.

Psoriasis. Presented by DR. MAX SCHEER.

Herpes Zoster. Presented by DR. MAX SCHEER.

Arsenical Pigmentation. Presented by DR. MAX SCHEER.

A Case for Diagnosis (Pyoderma and Alopecia?). Presented by Dr. George M. Lewis.

Chronic Eczema. Presented by Dr. George M. Lewis.

Granuloma Annulare. Presented by Dr. Max Scheer.

Acrodermatitis Chronica Atrophicans. Presented by Dr. Max Scheer.

J. Gardner Hopkins, M.D., *Chairman*

March 2, 1937

David Bloom, M.D., *Secretary*

Cornu Cutaneum. Epithelioma. Lupus Vulgaris. Presented by Dr. A. Benson Cannon.

This patient, A. L., is a woman aged 81. At the age of 9 years, a small lesion developed on the left side of the face, which was treated for the first time when she was 14, with some caustic preparation. Spreading followed. She received no further treatment until the age of 40, when the lesion was "burned" again several times, without improvement. She has received no treatment for this lesion of lupus vulgaris since that time. A year and a half ago the patient suffered a severe injury to the left side of the jaw, and there was considerable bleeding. When this healed, a hard growth appeared, which has grown larger. This has not been treated up to the present time. The general health was good until the development of gangrene of the left leg, which necessitated amputation in December, 1936. The patient now has arteriosclerotic gangrene of the right heel.

On the left side of the face, from the middle of the cheek down over the jaw, there is a whitish scar which here and there shows typical apple jelly nodules. The posterior and lower portions of the lobe of the left ear are similarly involved. There is a group of typical pea-sized apple jelly nodules under the chin. From the left commissure of the mouth down to the lower border of the chin is a hard yellowish horn the size of a quarter, elevated 1 inch (2.5 cm.) above the surface. The base, especially its upper edge, is elevated, red and distinctly rolled at the edges. The glands of the neck are not enlarged. The Wassermann reaction was indefinite with both antigens.

DISCUSSION

Dr. E. William Abramowitz: I should like to call attention to the fact that this woman has had lupus vulgaris for a long time and has had no roentgen treatment; yet an epithelioma developed.

Dr. A. Benson Cannon: I show this woman merely to demonstrate an unusually large cutaneous horn with what is apparently carcinoma at its base. The whole thing is engrafted on lupus vulgaris of long standing.

Primary and Secondary Syphilis. Pigmentation from Secondary Lesions. Lymphogranuloma (?). Presented by Dr. A. Benson Cannon.

Z. K., a Negress aged 20, was seen on Feb. 2, 1937, with a generalized eruption of six weeks' duration. Physical examination shows a generalized brownish red macular and maculopapular eruption, most pronounced over the seborrheic area of the face and the extensor surfaces of the arms. The palms and the soles are scaly. There are a dime-sized raised indurated lesion on the left labium majus and moist papules on the labia minora. There was a painful enlarged left inguinal gland, about the size of an almond, which later broke down and drained moderately.

The Wassermann reaction was 4 plus on Feb. 3 and on Feb. 8, 1937. The results of a Frei test were positive and those of a Dmelcos test negative on Feb. 17, 1937. The patient has received seven injections of arsphenamine and three injections of a bismuth preparation.

DISCUSSION

DR. LOUIS CHARGIN: During the active stage of secondary syphilis the Frei test not infrequently gives negative results and hence is unreliable.

DR. A. BENSON CANNON: I think that is true. This woman even now has active secondary syphilis. Most of the lesions have undergone involution, but she still has plaques and papules.

Secondary Syphilis. Presented by DR. A. BENSON CANNON.

W. M., a man aged 20, presents a primary penile sore which developed about two months ago. This is accompanied with a yellow, purulent urethral discharge. A private physician treated him with a gonococcus vaccine for about ten days, at the end of which time a generalized eruption developed, beginning on the forehead and gradually spreading over the body. At this time the Wassermann reaction was positive. The patient received two intramuscular injections at the Fordham Hospital and was then transferred to the New York City Hospital for further treatment.

Examination shows a generalized eruption of the entire cutaneous surface, with grouped, papular lesions predominating, along with scaly and psoriasiform lesions and other large rupia-like eruptions on the trunk and the back. There is a psoriasiform eruption of the scalp, with many pustular areas near the margin of the hair posteriorly. The pharynx is red. Moist papules are seen in the axillae and the perianal region. There are no palmar or plantar lesions. The prepuce is dark red, indurated and phimotic, preventing examination of the glans. There are a yellow, purulent discharge from the anterior part of the urethra and generalized adenopathy. Two dark field examinations on successive days gave negative results. Results of the Wassermann test of the blood have not been reported.

DISCUSSION

DR. A. BENSON CANNON: My object in presenting this man is twofold. He shows an extraordinary variety of pronounced secondary lesions and has had ten injections of some sort within five weeks, according to the history. More recently he has had two injections of a bismuth preparation. The lesions have improved a great deal since the injection of the bismuth preparation.

DR. CHARLES WOLF: This patient was shown at another dermatologic meeting a week ago, and at that time the lesions were more hypertrophic. They were more crusted—so much so that many of the lesions appeared to be those of varioloid. One of the men at the meeting discussed at great length the differentiation between variola and this type of pustular syphiloderm. The drug received by the patient from the private physician has to be ascertained. The question of a malignant type of syphilis, not responding to specific treatment, is conjured up in this case. The patient looks run down. It seems to me that one could get a rapid effect by giving this man a diet high in carbohydrates and vitamins, in conjunction with the antisyphilitic treatment. I therefore feel that the point that ten treatments with arsphenamine were followed by an apparent intensification of the eruption has not been proved.

DR. LOUIS CHARGIN: I had occasion to see this patient elsewhere about two weeks ago and made a diagnosis of papulopustular syphiloderm resembling smallpox. At that time, too, a history was obtained that he had received ten injections, just prior to presentation, but it was not ascertained just what the injections were. I did not think that the drug was an arsenical preparation, because there had been no therapeutic response. The patient is now showing much improvement following two injections of a bismuth preparation. This serves to confirm the impression that the ten injections previously given were not of an arsenical preparation, for

there is no reason to suspect that this type of syphilis fails to respond to the arsphenamines.

DR. A. BENSON CANNON: I think that, irrespective of what kind of treatment this man had before, the fact that he did not have the proper sort has been demonstrated by the way the condition has cleared after two injections of a bismuth preparation. One of my associates looked up the physician who treated the patient on the outside, and I hope to have more information on this later. (NOTE.—The preparation was not arsenic.) However, I have a case in my records of a minister who consulted a dermatologist and was treated for two years continuously, and in that period he missed only two weeks of treatment. He had seldom, if ever, been without lesions of the skin and the mucous membrane. When he consulted me he still had lesions. I demonstrated spirochetes in the secretion taken from the lesions. I have photographs of the lesions on the tongue, the scrotum, the penis and other parts of the body, and I have the outline of treatment from his physician. Such cases are unusual but not unheard of. I have photographs of some ten or eleven other patients who have received neoarsphenamine and whose lesions have persisted throughout the period of treatment and cleared rapidly after therapy with old arsphenamine was instituted.

Sycosis Vulgaris, Showing Results of Manual Epilation. Presented by DR. A. BENSON CANNON.

N. S., a man aged 38, states that he first noticed a small sore on the left side of the face eleven years ago. The lesion gradually spread to involve the entire bearded region and then gradually cleared and did not recur for four years. It returned then but cleared completely under grenz irradiation (1931). The face remained clear until two months ago, when the condition recurred on the face and the scalp at the same time.

Examination shows on the upper lip, the chin, the sides of the face and the scalp numerous pustules each of which is pierced by a hair. There is some scarring, especially on the sides of the face. The Wassermann reaction was negative. Manual epilation, application of an ointment containing 10 per cent salicylic acid twice a day and injections of foreign protein in the form of sterile milk have been employed.

DISCUSSION

DR. HERMAN GOODMAN: I have tried the other extreme in treatment, letting the patient grow a beard, and have thought the success was as good as Dr. Cannon's.

DR. A. BENSON CANNON: Dr. Goodman's treatment is much more simple, and if it accomplished the same result I should prefer it. I have observed cases of general sycosis involving the scalp and suprapubic and axillary regions in persons where hair is long.

This man has a chronic condition of the skin which is resistant to treatment, one for which the usual treatment is epilation by irradiation. Often, this brings such beneficial results that the patient when he has a recurrence wants more roentgen irradiation, which almost invariably leads to roentgen ray changes in the skin. In this case, as the patient had had a questionable amount of roentgen treatment, I had his friends in the hospital epilate him manually. This treatment is not painful if the skin is pinched between the fingers and is most effective and harmless. If a man perseveres in this epilation, he gets a permanent cure. I think that the secret of success is to keep pulling hairs for the next six months after the patient is apparently well.

Psoriasis. The Problem of Treatment. Presented by DR. A. BENSON CANNON.

J. I., a man aged 66, has had psoriasis for the past ten years. The eruption cleared in the summer and recurred in the winter until a year ago, when he was admitted to the New York City Hospital because of widely distributed psoriasis,

with marked scaling and fiery red patches. He was given one bath in a solution of sodium bicarbonate and a scrubbing with a brush, without other medication. The marked generalized redness and scaling of the entire body were aggravated, requiring weeks of bland treatment to quiet down. Application of chrysarobin (0.1 per cent) was tried next, and the generalized redness and scaling immediately returned. Similar results occurred after the use of salicylic acid, tar and ammoniated mercury. The patient has received his full quota of roentgen irradiation and has had ultraviolet irradiation and fever therapy.

DISCUSSION

DR. FRED WISE: Dr. Cannon mentioned fever therapy. I do not know if the patient is able to tolerate that, but if he is I should be inclined to give him typhoid vaccine. Another suggestion for therapy is the continuous warm water bath.

DR. A. BENSON CANNON: At various times sterile milk and colloidal manganese have been used, as well as typhoid vaccine. Sodium bicarbonate and bran baths have been tried, but only for two or three hours daily.

DR. BEATRICE M. KESTEN: I should suggest large doses of crude cod liver oil. In three patients with marked psoriasis, two of whom had arthritis as well, massive doses of crude cod liver oil, up to 120 cc. a day, relieved the arthritis and definitely helped the psoriasis.

DR. A. BENSON CANNON: I have been much interested in this old man, because every form of treatment has almost invariably aggravated the condition. When he was first admitted to the hospital, I think his psoriasis was one of the most pronounced eruptions of this type which I have ever seen. There were a great many inflamed lesions and some pus in the lesions here and there. I prescribed the usual soothing treatment for that type of psoriasis, applications of olive oil and soothing baths. The condition was much improved. When it reached the stage of quiescence and the time for something more irritating had arrived, 0.1 per cent chrysarobin was used, and the condition immediately flared up with an exfoliative dermatitis. Tar in a small percentage was tried later, with a similar result. Ammoniated mercury and even salicylic acid have aggravated the condition. The patient's general health was considerably below par. He was thin and pale and had bad teeth, and it was suggested that his psoriasis was in some way connected with his general debility. I have noticed that when patients have a focus of infection somewhere the psoriatic lesions are inflammatory and do not respond to the usual remedies. No therapy has been used lately except applications of olive oil and of hydrous wool fat. Fever therapy has been considered. The patient has gained from 25 to 30 pounds (9.3 to 11.2 Kg.) and is in improved general health. His psoriasis, too, has improved but has never disappeared.

Allergic Dermatitis. Presented by DR. A. BENSON CANNON.

S. R., a Polish man aged 47, has a generalized eruption of nine years' duration. At the onset the condition was pruritic, with oozing "pimples" on the backs of the hands and the extensor surfaces of the forearms. The eruption spread to the face and then to the trunk, becoming generalized in about ten weeks. The patient was employed as an upholsterer. He was treated by four dermatologists during the first year, and after one generalized roentgen treatment and an intravenous injection he suffered an acute outbreak, with fever, marked redness and edema, followed by exfoliation and loss of the nails. According to the patient's statement, after three intramuscular injections into the hip of a preparation of colloidal silver, the lesions became markedly bluish, and that color has persisted. The condition was considerably improved when benzene was applied locally and a preparation prescribed by Unna in Germany was taken by mouth. The patient has been in numerous hospitals and has experienced improvement at times. He has had forty roentgen treatments over the entire body, two hundred injections of sodium thiosulfate, numerous ultraviolet treatments, nonspecific therapy with typhoid vaccine and sulfur baths at Hot Springs, Ark. The last caused great improvement.

Examination shows universal lichenification and brownish discoloration of the skin, with numerous raised bluish red infiltrated plaques and streaks ranging in size from that of a pea to that of an almond and appearing mainly on the trunk and the inner aspects of the thighs and the arms. The skin is dry, with fine desquamation, mainly on the lesions. All the superficial lymph glands are slightly enlarged.

Numerous blood counts showed no abnormality. The Wassermann test was negative and urinalysis and chemical examination of the blood showed no abnormality. Examination of the blood showed 0.09 mg. of arsenic per hundred grams of solid matter, and examination of the skin showed no sign of arsenic. There was no melanin in the blood. The urine showed 405.1 mg. of melanin in 1,650 cc. of urine. Several histologic examinations of the skin showed chronic inflammation. Examination on Feb. 11, 1937, showed "chronic dermatitis."

DISCUSSION

DR. A. BENSON CANNON: The members have all seen this man many times. He has what we have chosen to term an allergic dermatitis, for lack of a better term. Histologic sections have shown simply an inflammatory condition, a dermatitis. I have had other similar patients. On hospitalization they always get well within a few months with almost any kind of treatment. Ultraviolet irradiation does as well as or better than anything else, and tar ointment is helpful. The condition improves when the patient is sent to a warm climate. I had one patient who had a recurrence on returning to his old apartment and another one on returning to his old job. I have recently had the social service department send two such patients to a warm climate. Jobs were obtained for them in New Mexico recently, and I had a card today from one of them who reported that they are 70 per cent better, although they have been there only a few days. He said he is going to make that place his home forever.

DR. MARION B. SULZBERGER: I think the case presented this evening is similar to the cases which have been the object of discussion in various meetings in New York. In my opinion, this case is similar to the cases which Dr. William Garbe of Canada and I have tried to describe and to discuss fully in an article in the ARCHIVES (Sulzberger, M. B., and Garbe, W.: Nine Cases of Distinctive Exudative Discoid and Lichenoid Chronic Dermatosis, ARCH. DERMAT. & SYPH. **36**:247 [Aug.] 1937). I cannot here go into the details of what was found in the nine cases Dr. Garbe and I studied. However, I would like to stress one or two points which Dr. Cannon brought up. One point is that eruptions like this are in certain respects characteristic. They do resemble one another, and study will show that they do not resemble other forms of eczematoid dermatitis. Another point is that there seems to be some environmental factor in the production of this type of dermatitis. The patients I have observed have all been males and, with no exception, I believe, Jewish males. They have as a rule recovered with varying degrees of promptness on hospitalization, and the condition has recurred on their return to certain environments.

Not all my patients have experienced improvement on going south. One patient came back from Miami, Fla., in much worse condition than when he went. Apparently the allergens to which these patients are sensitive (if the dermatosis is due to allergens) are sometimes confined to one locality and sometimes found in more than one place. Another peculiarity of cases of this type is that often all forms of cutaneous tests which I have employed have given negative results. Eosinophilia is a fairly constant characteristic, however. An average of over 9 per cent eosinophils was found in our cases. I believe that such cases represent a large group with a fairly characteristic picture, which has now been studied sufficiently to allow for clear distinction and segregation from cases of contact dermatitis, atopic dermatitis, seborrheic dermatitis, "nummular eczema," prurigo, neurodermatitis and other forms of eczematoid eruption.

DR. CHARLES WOLF: The longer these cases are observed, the closer dermatologists are getting to the point where it will be possible to find the causative

factor. It seems to me the picture is becoming rather concrete in its evolution, in its morphology and, finally, in the terminal stages of the disease. I was glad to hear Dr. Sulzberger stress a point which I have had in mind for a long time since observing some similar cases. The environmental factor is all important. The condition starts as one of allergic type. The patients are sensitive to certain foods in the beginning. As the disease progresses the sensitivity to foods is somewhat abated and the patients become sensitive to environmental factors, the principal ones being dust and—one which I have found to be the culprit in most cases—wool in various articles, especially woolen blankets. It will be noticed that the condition is always worse in the winter. It seems there is a certain type of wool in the bedcovers which aggravates this disease. The condition clears in the summer, when blankets are not used and plain cotton sheets are substituted. I believe the condition is a dermatitis caused by contact with wool, but I have not had any positive results on cutaneous tests.

DR. HENRY D. NILES: This patient was in the New York Hospital some time ago, and the feature which interested my associates and me particularly was the color of his eruption. There was a dark pigmentation. Everything else improved a good deal when he was hospitalized, but the color did not fade at all. On account of the color, Dr. L. E. Gaul performed a spectroscopic examination and found a marked increase in the copper content. After that rather surprising finding we learned that the patient was an upholsterer and used to have the habit of putting copper tacks in his mouth while he was at work. We considered the possibility that absorption of copper had caused this color.

DR. J. GARDNER HOPKINS: There is one point which has been brought up on which I should like to comment. I think both Dr. Cannon and Dr. Sulzberger agree that while the condition may be thought of as allergic, it has nothing in common with atopic eczema. In my experience the patients have never been shown to be sensitive to any food or protein or to possess any allergy of the type seen in infantile eczema or the late form called neurodermatitis, a definite entity generally recognized as due to protein sensitivity. They do show what look like allergic phenomena to external things, but that does not explain the eruption. I think dermatologists have got into the habit of saying the condition clears in the hospital. Sam Ratner was in the hospital twelve months, and the condition got a little better but never cleared. These patients are often neurotic. The eruption is probably due to the patient's interminable tearing at his skin.

DR. A. BENSON CANNON: I have an idea that this eruption is not a new disease. I remember observing such cases at the New York City Hospital when I first went there, in 1916. Dr. J. A. Fordyce had one in his service for fifteen years. The patient subsequently died, and nothing relevant was found on postmortem examination. I think persons are more conscious of allergic states now than ever before, and consequently they take greater notice of this type of cutaneous disease.

A Case for Diagnosis (Pustular Bacterid?). Presented by DR. HENRY D. NILES

F. G., a white man aged 35, is presented because of an eruption on the hands, the feet and the legs of six months' duration. This started with vesicles on the fingers and gradually spread to the palms, the legs and the feet. The patient has had asthma and sinusitis for many years. He had dermatophytosis of the toes two or three years ago but not since. Eighty scratch tests and roentgenograms of the teeth showed no abnormality. The tonsils were removed within the past year. There has been no known exposure to external irritants. The patient has received six roentgen treatments and many local applications, with little or no relief. Recently he has had nonspecific urethritis and prostatitis. The patient is now receiving prostatic massage and injections of vaccine from prostatic pus twice weekly and is having treatment for his nose and sinuses. He is using anthralin ointment and a solution of potassium permanganate. At first he showed distinct

improvement from intramuscular injections of colloidal manganese, but in the past two weeks there has been a relapse. Injections of vaccines and other substances have caused no improvement, and they have been stopped. The last prostatic smear showed no pus cells. The eruption is worse when the condition of the sinuses and the nose is aggravated.

Examination shows many pinhead-sized pustules and vesicles and red scaly skin on the palms, with marked thickening and scaling on each hypothenar eminence. There is a roughly round red, scaly, thickened patch, less than the size of a palm and containing several pustules and vesicles, on the inner side of the right ankle, and a similar, smaller patch with a few pustules is seen on the outer side of the right ankle. There is a round red, scaly patch the size of a 50 cent piece on the right shin. There are a few discrete pinhead-sized vesicles and pustules on each sole and slight maceration in the last two interspaces of each foot. The third toe-nail of each foot shows subungual hyperkeratosis. The finger-nails are normal. There are no patches of psoriasis on the scalp, the elbows or the knees.

There was a marked reaction to intradermal tests with oidiomycin, dermatomycol and staphylococcus toxin. Culture from the lesions on the palms and the right ankle showed Staphylococcus albus; from the prostate, hemolytic Staphylococcus albus, and from the ethmoid sinuses and the nasopharynx, Staphylococcus albus and Streptococcus viridans. Several microscopic examinations of scrapings from the interspaces of the toes and the toe-nails showed no sign of fungi.

DISCUSSION

DR. DAVID BLOOM: Clinically the patient presents a picture of so-called pustular psoriasis. I wish to call attention to the scaly plaque in the web between the thumb and the index finger, which is frequently seen in psoriasis and in pustular psoriasis. Long observation of such eruptions strengthens one's belief in the justification of the name pustular psoriasis. A woman aged 70 whom I described in my article and presented several times before this section was observed this afternoon in the clinic. She presented an eruption on the palms which was so typical of ordinary psoriasis that the young physicians at the clinic diagnosed it immediately as such.

DR. GEORGE C. ANDREWS: I feel that there is no reason to make a diagnosis of psoriasis in this case. I did not see any lesions of psoriasis, and there is no history of this disease in the family. The patient has never had psoriasis. Whether the condition is pustular bacterid or not is another question. Many vesicular and pustular eruptions on the hands are neither. It may be pustular bacterid, and from what Dr. Niles has shown so far, that seems the most likely diagnosis. I think it is interesting in these cases to watch the blood count. In periods of quiescence it may be normal, but in some cases I have been astonished to get white cell counts as high as 14,000 or even higher. Before outbreaks of pustules I think the white blood cell count particularly is apt to go up. I had a letter from Dr. Barber about this subject just two days ago. He sent me some pictures of two patients with pustular bacterid. He expressed the belief that psoriasis and bacterid are separate entities. It is perfectly possible that the prostatitis or the pustular sinusitis in this case has something to do with the condition. However, that will not be known until further evidence of the relation is brought out. It is possible that some autogenous vaccine might be useful in this case if such medication has not already been tried. If the patient is cured by relief of the local infection, that will help in establishing the diagnosis.

DR. ANTHONY C. CIPOLLARO: This case fits in with my conception of pustular psoriasis, as first described by Barber. The points constantly emphasized in this disease are its obstinacy and its resistance to treatment. Of all the patients that I have observed and treated, not a single one was completely and permanently cured. My treatment included the removal of tonsils and other foci of infection. I should like to ask Dr. Andrews if in any of his cases of pustular bacterid there has been a complete and permanent cure.

DR. GEORGE C. ANDREWS: I certainly have had several cases in which there has been complete cure after removal of foci of infection. I saw a man the other

day whose wife had what I called pustular bacterid on both heels and thenar eminences. I tried to get her tonsils out for four years before reporting the case, but the tonsils were small and did not look bad. I thought they were definitely infected because of the hyperemia and congestion around them all the time, but there was some question as to whether they were involved. Acute otitis media developed about eight months ago, and after that quieted down she had her tonsils removed. Her husband came in to tell me that her eruption entirely cleared and has not reappeared. That is just one more case added to those that have already been reported. One of the first patients treated had sat for three summers with her feet in saucepans of solution of aluminum acetate, the only thing that would do them any good. She was about 60 years old. After her tonsils were removed, her hands and feet got entirely well and stayed well for about two years. Then carcinoma developed and she died. Those are some of the outstanding cases about which there is no doubt. Barber has had the same results. In fact, he has called attention in many of his reports of cases to the therapeutic results of removing foci of infection. He now believes there are two types of the condition, one which is not connected with psoriasis at all and which he calls eczematoid pustular bacterid and one in which the patient has psoriasis and a peculiar reaction which manifests itself in these pustular lesions. He believes there is little difference between the two types clinically but that the psoriasis tends to be more pustular and the bacterid a little more vesicular, although vesicles can occur in pustular psoriasis. I do not like to take the stand that all these conditions are bacterid, but some of them are, and there are some of these conditions which neither psoriasis nor bacterid explains.

Dr. J. Gardner Hopkins: I have had about four cases of long standing in which the condition has cleared entirely after removal of foci of infection. I think there are so many cases of that sort on record in the literature now that an inquiry as to whether they occur is hardly pertinent.

Dr. Henry D. Niles: At least three quarters of the lesions are vesicles. I think that is in favor of bacterid rather than psoriasis. As far as foci of infection are concerned, roentgenograms of the teeth showed no abnormality, and the tonsils have been removed. The patient had intensive treatment for prostatitis by a urologist, and the last two smears showed no pus cells or organisms. He never had any symptoms from the prostatitis. Nothing further can be done there; certainly prostatectomy is not indicated. The chronic ethmoiditis cannot be cured. He has had treatment with vaccines, mentioned by one of the discussers. Autogenous vaccine made from the cultures from the palms and soles and the prostatitc secretion combined was administered twice a week. At the same time he had prostatic massage twice a week, which produced no benefit. On his insistence vaccine therapy was discontinued after about five or six weeks. It was practically useless. He has definite outbursts of lesions which, to my mind, represent dissemination of toxins from some focus. One day he is relatively free from lesions, and two or three days later many new pustules develop within twelve hours. They then improve remarkably within a few days. Tonight his condition is at least 50 per cent better than it was when I saw him a week ago. I do not know what to do for him in the way of therapy. That is the biggest problem in cases in which it is impossible or not feasible to remove foci of infection or in which none can be found. I have seen improvement, at least temporarily, in this condition following administration of colloidal manganese, whereas in my experience such treatment never helps ordinary psoriasis. This observation is in line with the effect of the medication on furunculosis. I intend to continue its use for at least a few more injections before abandoning it.

Lymphogranuloma Venereum, Anorectal Type, Successfully Treated with Intravenous Injections of Frei Antigen. Presented by Dr. David Bloom.

T. D., a Negress aged 25, has suffered from painful and difficult defecation for the past ten years. She has not been able to move her bowels without taking

enemas or cathartics. She had a mucous and bloody discharge from the rectum. Examination in October 1936 showed a granular fibrous mucous membrane of the rectum, a marked stricture 8 cm. above the anus and several fistulas. The Wassermann reaction was negative, and the Frei test gave positive results.

Between Nov. 5, 1936, and Jan. 4, 1937, the patient received seven injections of Frei antigen made from mouse brains and two injections of antigen prepared from pus of human patients, in doses starting at 0.1 cc. and increasing gradually to 1 cc. Except for the fever, the constitutional reactions were slight. There was a tendency for the fever to diminish with successive injections; the first injection produced a temperature of 103.2 F. sixteen hours later. This persisted for forty-eight hours and returned to normal on the fourth day. The successive injections produced less fever, and the temperature reached normal on the second or third day.

After the first injection there was improvement in the general condition, and defecation was less painful and difficult. After three injections defecation became easy, and there was no soreness in the rectum. After two more injections the purulent discharge ceased almost entirely, although it had increased considerably immediately after each previous injection. The proctologist, Dr. E. I. Huppert, who examined the patient frequently, noted objective improvement. Although in the beginning the stricture could not be reached with the proctoscope, it was possible on December 9 to pass the proctoscope to the stricture. Dr. Huppert remarked on that occasion that the scar tissue in the anal canal was apparently softening.

DISCUSSION

Dr. David Bloom: For the past six months or longer my associates and I at the Bellevue Hospital have been using intravenous injections of Frei antigen in the treatment of lymphogranuloma venereum. The results obtained were better than those with antimony and potassium tartrate.

Dr. A. W. Grace: I have used Frei antigen prepared from mouse brains intravenously for the treatment of anorectal lymphogranuloma venereum. As the mouse brain antigen is stronger than most samples of human antigen, I begin with a small dose, 0.02 cc., followed by 0.05 cc. for the second and 0.1 cc. for the third dose. Successive doses are increased by 0.1 cc. up to 1 cc. Doses of less than 1 cc. are made up to 1 cc. with sterile solution of sodium chloride. Injections are given twice weekly for twelve doses in all. The first three or four injections are usually followed by a febrile response, but the degree of fever is generally less after the later injections. It is possible that patients with this condition do better with antigen administered intravenously than with that given subcutaneously.

Dr. Louis Chargin: I can substantiate the results mentioned by Dr. Grace, but with a different antigen. I have been using human antigen, with satisfactory results on glands as well as local sores. It is particularly gratifying when ulcerating local lesions that have persisted for long periods heal within a comparatively short time under intravenous injections of the antigen. I believe I can state that at present this is the best method of therapy known for the treatment of this disease.

Dr. David Bloom: I have used both mouse and human Frei antigen and found that usually the latter was weaker than the former. The temperature went as high as 105 or 106 F. after the treatment, but in most cases was 103 or 104 F. It is possible that instead of or besides the fever there is another factor, a specific one, which is responsible for the good effect of the treatment, for a series of patients not affected with lymphogranuloma venereum did not react with fever to intravenous injections of Frei antigen. In the beginning of my investigation I was more enthusiastic about this treatment than I am now. Not all the patients respond quickly and thoroughly. In some the iliac mass becomes prominent after the inguinal tumor diminishes. In anorectal involvement, the degree of improvement depends on the extent of the scarring process. Of all the remedies used so far in the treatment of lymphogranuloma venereum, this mode of attack impresses me as the most effective, although it is by no means satisfactory in every case, particularly

in inguinal involvements. In order to evaluate the factor of fever, I am using typhoid fever therapy in some of the patients. Comparing the effects of these two kinds of fever therapy will help to solve this problem.

Pemphigus of the Eye Associated with a Bullous Eruption of the Skin (Bullous Erythema Multiforme? Pemphigus? Epidermolysis Bullosa Acquisita?). Presented by DR. DAVID BLOOM.

E. G., a Negress aged 31, has had a sparse bullous eruption on the extremities, the face and the mucous membranes of the mouth and the nose for the past three years. The bullae were tense or broken and ranged in size from that of a pea to that of a bean. They appeared on the normal skin and were moderately pruritic. Some of the lesions appeared, according to the repeated statements of the patient, after trauma.

In July 1935 adhesions were noticed for the first time between the conjunctiva of the outer canthus of the lower left eyelid and that of the bulbus of the eye. Since then there has been progression in the ocular lesion. Today there are marked symblepharon, xerosis of the conjunctiva bulbi and infiltration and vascularization of the cornea. The band forming the adhesions covers the outer portion of the cornea with a sharp, advancing edge. The diagnosis made by the ophthalmologist was pemphigus of the eye and xerosis of the conjunctiva.

The skin of the upper and the lower extremities and the face shows hyperpigmented plaques, which correspond to the locations of previous bullae. On the dorsa of the hands there are a few small bullae and depigmented spots which are the results of healed bullae. There are numerous broken bullae on the mucous membranes of the cheeks, the palate and the pharynx.

The patient is in good general condition and has not lost weight. The laboratory examinations, including the Wassermann test, the erythrocyte sedimentation test, the blood count and the differential count, showed no abnormality except slight leukocytosis. The Pels-Macht test gave a nontoxic reading, 66 per cent.

DISCUSSION

DR. MARION B. SULZBERGER: In my opinion, the ocular lesion in this case is identical—except that it has not progressed as far—with that in the case which Dr. Martin Cohen and I described a few years ago (*Arch. Ophth.* **13**:374 [March] 1935). In our case the diagnosis of the ocular lesion was the same as that in Dr. Bloom's case—that is, essential shrinkage of the conjunctiva, a condition which the ophthalmologists usually call "pemphigus of the eye." Our case was that of a little boy with an atypical form of bullous eruption which we finally thought was epidermolysis bullosa. Essential shrinkage of the conjunctiva has been reported only two or three times in association with epidermolysis bullosa, and the same condition occurs with pemphigus and rarely with bullous erythema multiforme; so the presence of this ocular condition does not help in differential diagnosis. The differential diagnosis between these three conditions has to be made on the basis of the cutaneous disease. In this case I should favor the diagnosis of epidermolysis bullosa with essential shrinkage of the conjunctiva. In our case we demonstrated the absence, or marked diminution, of elastic fibers in the affected skin, in normal skin and in the ocular lesions.

DR. CHARLES WOLF: I should like to call attention to the fact that this patient had lesions on the mucous membranes of the hard palate.

DR. DAVID BLOOM: The eruption would favor the diagnosis of bullous erythema multiforme over that of pemphigus, but the insistence of the patient since the beginning of her illness a few years ago that the bullae appeared after trauma and, on the other hand, the development of the ocular lesion which is known as pemphigus of the eye and has been described mostly in association with pemphigus of the skin justify the consideration of the diagnoses of pemphigus and epidermolysis bullosa acquisita. Similar ocular lesions have been described in conjunction with these cutaneous diseases. I was able to observe the ocular lesion from the begin-

ning and have noticed marked progress in the process, for now a part of the cornea is involved. The ophthalmologists maintain that treatment is of no avail.

A Case for Diagnosis (Dermatitis Medicamentosa?). Presented by Dr. Henry D. Niles.

G. S., a girl aged 17, is presented because of a pigmented patch on the left cheek of two and one-half years' duration. She has on the left cheek a well demarcated area composed of two circular pigmented patches the size of a silver dollar. The pigmentation is not increased at the borders. There is no scaling, vesiculation, erythema or itching. The patient uses no cosmetics or perfumes. The present lesion started as a small spot and gradually increased to its present size. The patient takes phenolphthalein seldom and had taken none for at least two months before admission. When she was first seen she was advised to take 1 grain (0.06 Gm.) of phenolphthalein the night before her second visit. The following day there were itching and slight erythema on the sides of the nose and a few scattered pustules in the pigmented area. The patient took 2 grains (0.13 Gm.) of phenolphthalein two days ago, but this caused no eruption or itching. The Wassermann reaction was negative.

DISCUSSION

Dr. Louis Tulipan: I offer the diagnosis of chloasma.

Dr. E. William Abramowitz: I agree with the diagnosis of chloasma.

Dr. Henry D. Niles: I thought of chloasma but decided against it.

Dermatitis Venenata. Presented by Dr. A. W. Grace.

J. L., a man aged 54, unemployed, has an irregularly oval scarred area on the right side of the chin about 2 inches (5 cm.) long by 1 inch (2.5 cm.) wide. A few pinhead-sized pustules are present on the periphery of the scar. Two months before the development of the lesion, pustules similar to the present ones occupied the site of the scar. Not wishing to shave over the pustules, the patient applied barium sulfide powder to the area to remove the beard. Ulcerations followed, which led to the scarring now visible. The Wassermann and the Kahn reactions were negative, and the results of histologic examination were noncontributory.

DISCUSSION

Dr. Louis Tulipan: I venture the diagnosis of lupoid sycosis. It is the custom among orthodox Jews to apply barium sulfide to the beard and to take this off with a stick. Atrophy never develops as a result of that practice, which has been in use for many years. Here there is one small area which shows atrophy. I have not seen such a condition among at least 200 orthodox Jews whom I have seen who have used this method of shaving. The only thing ever seen is occasional dermatitis from the barium sulfide, which clears quickly under any soothing remedy but never produces atrophy.

Dr. A. W. Grace: Barium sulfide powder is used for the epilation of laboratory animals when it is undesirable to remove the hair by shaving. Injudicious use of the material often produces ulceration of the skin of the animals.

Tularemia. Presented by Dr. G. F. Machacek.

J. Z., a man aged 28, was forced to go to bed on Dec. 5, 1936, because of a temperature of 105 F., headache, cough, chills and sweating. He had been skinning rabbits and on December 1 had cut his right index finger. The axillary glands became extremely large, and spontaneous rupture occurred on February 9, leaving a draining sinus. His pulse rate varied between 60 and 116, with the average about 90. The temperature gradually went down to 100 F. but rose in the fifth week to 103 F. At present it ranges between 98.6 and 99.6 F. There has been

enlargement of the spleen and the liver. Examination of the heart showed extra systoles. Acute nephritis developed and later subsided, but there is still persistent albuminuria.

Two guinea-pigs were inoculated with material from the patient during the first week of the illness. Both died with typical lesions of tularemia. On the sixth day of his illness an intradermal test with Foshay serum gave positive results. On the sixteenth day an agglutination test for Pasteurella tularensis showed a titer of 1 to 320. From one guinea-pig gram-negative bacilli were recovered in a culture on cystine blood agar.

Primary and Secondary Syphilis. Neurosyphilis. Scrotal Tongue. Presented by Dr. A. Benson Cannon.

Dermatitis Exfoliativa. Presented by Dr. A. Benson Cannon.

A Case for Diagnosis (Sycosis?). Presented by Dr. Henry D. Niles.

Multiple Pigmented Hemorrhagic Sarcoma. Presented by Dr. G. F. Machacek.

Psoriasis Resembling Seborrheic Dermatitis. Presented by Dr. Leslie Paxton Barker.

Lymphogranuloma Venereum. Presented by Dr. A. Benson Cannon.

Recklinghausen's Disease. Presented by Dr. E. William Abramowitz.

Secondary Syphilis with Pigmentation. Presented by Dr. A. Benson Cannon.

Lupus Erythematosus and Infectious Eczematoid Dermatitis. Presented by Dr. A. Benson Cannon.

J. Gardner Hopkins, M.D., *Chairman*

April 6, 1937

David Bloom, M.D., *Secretary*

Mongolian Spots. Presented by Dr. Harry C. Saunders.

M. E., a girl aged 7½ months, is presented because of lesions located on the back, the buttocks, the ankles and the dorsa of the hands. Examination shows on the sacrum and the buttocks a poorly defined large greenish macule. The color is rather faint. On the back the lesions have a deeper color, are sharply defined, and vary in size from 2 to 4 cm. in diameter. There are eighteen such spots. The lesions on the hands resemble those on the sacrum.

DISCUSSION

Dr. Charles Wolf: Genetically this case is interesting because of the patient's mixed ancestry. The mother is of Polish descent, and the father is a Filipino. Mongolian spots are more apt to occur in the colored races, and it seems the dominant atavistic trait in this patient is from the Mongolian side. The condition is rather rare in a pure Caucasian.

Neurodermatitis Disseminata and Bronchial Asthma. Presented by Dr. George M. Lewis.

M. T., a woman aged 31, has had an eruption on her skin since she was 3 months old and has had bronchial asthma for the past fifteen years. The eruption and the bronchial asthma tend to alternate in intensity. She suffered from attacks of petit mal at the time of the menses between the ages of 16 and 21. Two years ago, when she was placed on a ketogenic diet, the cutaneous lesions cleared completely. Cutaneous testing in the past revealed numerous antigens, but clinical improvement did not follow their removal from the patient's environment. Cutaneous tests at present reveal sensitivity to ragweed, orris, stock dust, silk, sweet potato, buckwheat, raspberry, grape and apple. There has been an improvement during the past week, since the patient has been in bed. During this time she has used bland applications and has been on a ketogenic diet.

Examination shows an extensive erythematous eruption, dry, lichenified and scaly. The face, the neck and the flexor surfaces of the arms and the legs are the main sites affected. There are numerous excoriations and a few secondary pustules. Palpable lymph nodes are present in the axillary, the inguinal and the posterior cervical area.

DISCUSSION

Dr. J. Gardner Hopkins: I am interested in the terminology of this condition. I believe the term recognized for this condition is allergic eczema, which seems to me logical. I should like to ask Dr. Lewis if the patient had typical infantile eczema, and if so whether he thinks the disease the patient has now is different from the one she had in infancy.

Dr. George M. Lewis: The patient gives a history of having eczema since early childhood. Whether the original eczematous attack was of the same nature would be difficult to determine, but it is logical to assume that the present condition began shortly after birth and has remained as atopic eczema. It is probably sound to consider the disease atopic eczema, but for practical purposes the condition should not be considered solely a congenital allergic eczema. Other causal factors have been brought out by Becker and Stokes and others. Individual study is often required in order to elicit them.

A Case for Diagnosis (Sarcoid? Tertiary Syphilis?). Presented by Dr. Nathan Sobel.

R. K., a woman aged 35, is presented because of an eruption on the upper part of the left arm of two years' duration. The patient presents a depressed firm area, irregular and faintly purplish, about 2 inches (5 cm.) in diameter, with adherent epidermis, on the upper external aspect of the left arm. The mass is nodular and deep, apparently reaching the periosteum. There is no pain or itching. The patient's general health is good. There is no history of trauma. Two years ago, when she was in Jamaica, British West Indies, the patient was bitten on the outer surface of the arm by an insect. A swelling resulted but subsided quickly. There were no sequelae. A few months later the patient noticed a small lump in the skin, which became larger and deeper as time went on. She noticed that the skin became retracted below the general level.

A tuberculin test with 1:1,000,000 dilution gave negative results and those with dilutions of 1:100,000 and 1:10,000 gave results of 4 plus and 2 plus, respectively. The Wassermann and the Kahn reactions were negative. Two complete blood counts were normal. A roentgenogram of the chest showed no abnormality except moderate old lymphoid nodulation in the central portion of the chest. A roentgenogram of the left humerus showed comparatively normal osseous structures and a deep subcutaneous fiber-like increase in the density of the soft tissue on the external aspect, on a level with the insertion of the deltoid muscle. Histologic examination showed a picture which might fit in with some type of leukemia.

DISCUSSION

DR. EUGENE F. TRAUB: The patient told me that she had received injections for a cold about six years ago and that she had had boils, but I am not certain now whether she stated that she had injections for her boils. However, all injections she did receive were given in the area where her present lesions are. The nodules now to be seen were not present at the time of the injections. I am not at all certain that she received an oil or paraffin preparation which might later produce a tumor of the paraffinoma type.

DR. ISADORE ROSEN: It is of interest in connection with this case that the pathologist reported that the histologic picture would fit in with leukemia. On clinical grounds alone, it is difficult to arrive at a definite diagnosis. The skin itself appears to be perfectly normal. As the patient gives a history of having had injections in this area, Dr. Traub's suggestion that they might be responsible is to be considered.

DR. A. W. GRACE: There was a woman at the New York Hospital about two years ago who had a condition similar to this except that it was much more widespread. She had had a pelvic operation elsewhere previously, and immediately afterward a clysis had been given in the submammary region on each side. About three months after that she noticed a hard, woody deep swelling in the region of each of the clyses, which spread and covered a greater part of the lateral aspect of the chest. Histologic examination of the lesion showed the picture of Darier-Roussy sarcoid. A little later, histologically and clinically similar lesions developed on the thighs. The patient was followed for two or three years, during which time the lesions as a whole diminished in size. The only treatment given was supportive and generalized ultraviolet irradiation.

DR. FRANK C. COMBES: I believe the condition mentioned by Dr. Grace has been reported frequently as panniculitis. When I examined this patient, that diagnosis suggested itself to me because of the feel of the nodules. They are firm, irregular and located beneath the skin. However, the histologic examination reports no injury or infiltration of the fat trabeculae. The histologic picture in many cases of panniculitis is indistinguishable from that of Darier-Roussy sarcoid.

DR. GEORGE C. ANDREWS: I was struck by the similarity between this case and one of lipogranulomatosis which I observed in the clinic recently. Considering the facts that this condition started after trauma and that there is a definite histologic picture of irritation of the fat tissue, I think that this diagnosis is the most suitable one. The boardlike infiltration is due to the edematous and inflammatory zone about the degenerated fat.

DR. NATHAN SOBEL: It is impossible to arrive at a diagnosis in this case. The lesion apparently can best be fitted into the picture of deep sarcoid, but none of the laboratory findings seem to bear that out.

A Case for Diagnosis (Lesions on the Back). Lupus Erythematosus of the Face. Presented by DR. A. W. GRACE.

S. H., a man aged 27, presents erythematous areas on the face, the ears, the arms and the neck, which appeared six months ago. The areas increased in size, and those on the arms lost much of their erythematous tint, becoming in parts paler than the surrounding skin. The lesions on the face and the neck spread and became slightly elevated. During the past six weeks, portions of the involved areas have assumed a dirty brown tint, and the tissues over the malar bones have become somewhat puffy. There have been no subjective symptoms, and the general health has been excellent. There is no history of venereal disease. Six weeks ago small deep swellings began to arise on the back and have since continued to appear.

On examination, the greater portion of the skin of the cheeks, the nose, the forehead, the ears and the neck presents a slightly elevated scaling erythematous

eruption, which is in parts finely verrucous and dirty brown. In one area, anterior to the left ear, there are erythematous nodules, about 1 cm. in diameter, arranged in a roughly circular manner. The outer aspect of the upper part of each arm is occupied by a palm-sized atrophic area of skin, the central portions of which are infiltrated and erythematous. In the middle of the back are about a dozen pea-sized nontender discrete and confluent firm nodules, over which the skin is erythematous. Over the summit of the nodule the skin is somewhat paler than over the remainder of the lesion.

Histologic examination of the lesions on the neck showed the end-stage of lupus erythematosus. Histologic examination of a nodule taken from the back showed the end-stage of an undiagnosed process. The results of the Wassermann and the flocculation test were strongly positive. Tuberculin tests, a roentgenogram of the chest and blood counts were noncontributory.

DISCUSSION

DR. FRANK C. COMBES: The interesting feature in this case is the presence of so many pustules and crusts on the face. However, if the condition is not lupus erythematosus, I do not know exactly what to call it. There are, nevertheless, many minor elements that are against a diagnosis of lupus erythematosus. I think the tenderness of the lesions on the back is against sarcoid. Those lesions remind me much of iododerma, especially when considered together with the pustules on the nose and the edema of the face. I questioned the patient as to the ingestion of medicines but could get no definite history of the intake of iodide. He may possibly have taken it in some form other than medicine. I think tenderness is characteristic of all cutaneous lesions due to iodides and bromides.

DR. ISADORE ROSEN: It is difficult on superficial examination to arrive at a definite diagnosis in a case like this, but I should like to suggest another possibility, and that is the Senear-Usher type of pemphigus. The lesions on the face and on the back simulate that form of pemphigus. The pathologic picture showed the presence of vesicles and was not characteristic of lupus erythematosus. These observations would sustain the diagnosis of Senear-Usher pemphigus.

DR. A. W. GRACE: The report on the histologic examination is noncommittal. An interesting point is that it shows intra-epidermal vesicles. If one looks closely at the face, particularly below and in front of the left ear, one can see some definite circinate lesions. The result of the flocculation test was 4 plus. The complement fixation test gave negative results. The case is presented for diagnosis of the lesions in the middle of the back.

Lupus Erythematosus, Showing Remarkable Improvement After Administration of Sodium Thiosulfate. Presented by DR. HENRY D. NILES.

F. H., a woman aged 30, is presented because of an eruption on her face of two years' duration. The eruption started as a small spot, which spread following roentgen therapy. Before coming to the clinic she had received thirty injections, ten of which were of a gold preparation, without any improvement. She was first seen in the clinic on July 30, 1935. At that time many coin-sized scaly erythematous patches with sharply outlined red borders and atrophic centers were scattered over her face. She was given twelve injections of sodium gold thiosulfate and twelve injections of bismuth subsalicylate, without any improvement, and new lesions appeared during the treatment. Since Jan. 21, 1936, she has received sixty-two injections of plain sodium thiosulfate, which have resulted in continuous marked improvement.

Roentgenograms of the teeth and of the chest showed no abnormalities. Roentgenograms of the sinuses showed only slight membranous infiltration of the right ethmoid cells. Chemical examination of the blood showed no abnormality, and the Wassermann reaction was negative. The general physical examination and urinalysis showed no deviation from normal.

Examination at the present time shows several coin-sized round sharply outlined pigmented atrophic patches scattered over the center of the face. There are only a few remains of active scaly red lesions, chiefly near the outer side of the left eyebrow. The patient is presented to demonstrate the remarkable improvement following administration of sodium thiosulfate after gold and bismuth preparations had been given without causing any improvement.

DISCUSSION

DR. EUGENE F. TRAUB: It always surprises me to hear what large numbers of intravenous injections of gold preparations are given to patients who apparently show little response to this remedy. No doubt the dermatologist is hopeful that if he continues treatment long enough with gold he will eventually achieve a result. But is this the usual experience? It certainly is not my experience. When a patient has not shown tremendous improvement with about a dozen intravenous injections of a gold compound—or twenty at the outside—I usually select another method of treatment. The same applies to bismuth. It seems that since these two remedies have become popular dermatologists have forgotten all the more simple methods of treatment for lupus erythematosus used previously. For patients with localized lesions, one might first try an application of tincture of iodine or white lotion. Later, if that was unsuccessful, one might attempt the application of trichloroacetic acid or of small amounts of solid carbon dioxide. I can recall many cases in which such comparatively harmless local remedies have cleared the condition with much less trauma and hardship to the patient than might result from the too long-continued use of either a gold or a bismuth preparation.

DR. ISADORE ROSEN: I should like to say a word in support of the treatment of lupus erythematosus with intramuscular injections of a preparation of bismuth. In a series of cases at the Mount Sinai Hospital satisfactory results were obtained by giving the patients two or three courses of twelve injections of a bismuth preparation at weekly intervals, with a rest period of two months between courses.

DR. HENRY D. NILES: I did not intend to imply in this case that the improvement was due to the sodium thiosulfate. I admit it may be a delayed effect of the previous treatment, but the fact remains that the condition not only did not improve but new lesions appeared during the administration of gold and of bismuth compounds. After the use of sodium thiosulfate was started, no new lesions appeared, and the old lesions disappeared. I have had the same experience in other cases. In cases in which gold has not been effective in the first place, after a course of sodium thiosulfate the gold has been more effective than it was in the beginning of treatment. I think in some cases the failure to respond to treatment is because of foci of infection. This patient has been examined carefully from that standpoint, and there has been no indication that such foci exist. I think she has had an enormous number of injections of sodium thiosulfate. I believe she had injections more frequently than once a week, at least in the beginning, so that there has been less than a year of therapy.

Lupus Erythematosus and Livedo. Presented by DR. HENRY D. NILES.

E. W., a woman aged 37, is presented from the dermatologic clinic of the New York Hospital because of an eruption on her face of ten years' duration. When she was 10 years of age, scrofulous glands were removed from the right side of her neck. At this time there was general glandular enlargement. At the age of 28 the patient had pleurisy, and the following year she had a mild relapse, but the presence of tuberculosis was not proved. Last summer she had severe night sweats, and occasional sharp pains accompanied respiration. The present eruption started with small scaly red areas below the eyes, which spread laterally and itched intensely. Following some injections these disappeared for eighteen months, but since then similar patches have appeared at least once a year, most

often in the spring, and the patient has never been free from the eruption for more than a month. For five years before coming to the clinic she had weekly injections. The patient used to work in front of a hot coal stove during the winter in Sweden and then walked for some distance to her home in the cold. She thinks that this is the explanation for the congestion of her face.

In April 1936 new patches appeared on the face and lesions developed for the first time on the ears, the neck, the chest, the arms and the hands. These were extremely itchy and were irritated by rubbing. The patient was first seen at the New York Hospital on June 9, 1936. At that time examination showed a large butterfly-shaped erythematous lesion, with scaling and plugged follicles, on the nose and the cheeks. There were similar lesions on the ears and tender slightly elevated red lesions the size of a bean on the forearms, the upper part of the chest and the hands. Almost the entire face was dusky red. There were a few râles at the apex of the left lung. Gynecologic examination showed cystic cervicitis. A roentgenogram of the chest showed no evidence of old or recent tuberculosis. The patient has had pain but no swelling in her knees and her shoulders. Since last fall there has been some swelling of the joints of the fingers.

Roentgenograms of the teeth showed no abnormality. The Kline test was negative. Chemical examination of the blood showed 107 mg. of sugar per hundred cubic centimeters. Urinalysis and a complete blood count showed nothing relevant. Histologic examination of a lesion removed from the chest showed hyperkeratosis, with clusters of lymphocytes and an occasional plasma cell, increased fibrous tissue and some perivascular infiltration. Examination of the nose and the throat revealed no foci of infection.

Since June 1936 the patient has received fifteen injections of sodium gold thiosulfate (from 10 to 75 mg.), sixteen injections of 0.5 cc. each of bismuth subsalicylate and eight injections of sodium thiosulfate. During this time she has shown slight improvement, and at times the injections have been followed by various types of reactions, including headache, flushes, chills and pains in the joints. In the past two weeks a few red papules have appeared under the chin.

Xanthoma Tuberosum Multiplex. Presented by DR. LESLIE PAXTON BARKER.

J. P., a Puerto Rican man aged 32, a postal clerk, is presented from the Vanderbilt Clinic. The eruption began eighteen months ago as small nodules, first appearing on the extremities. The lesions have increased in number since then. Some of the lesions disappear, but new ones always appear. The patient underwent duodenorrhaphy for a perforated duodenal ulcer in February 1936.

Examination shows a generalized eruption, most marked over the extensor surfaces of the extremities, especially on the elbows, the knees, the upper parts of the thighs and the buttocks and across the upper part of the back. The lesions range in size from that of a pinhead to that of a pea. They are discrete, conglomerate, yellowish and of firm, shotty consistency. There is some tenderness on pressure. There are no lesions of the mucous membrane. New lesions have appeared in areas of dermatitis produced by adhesive tape. The examination of the eyegrounds showed no abnormality.

Chemical examination of the blood showed 94 mg. of sugar, 2.8 mg. of uric acid, 16 mg. of urea nitrogen, 1.5 mg. of creatinine and 308 mg. of cholesterol per hundred cubic centimeters. Examination of the urine and a sugar tolerance test showed no abnormality.

Multiple Xanthoma. Presented by DR. LESLIE PAXTON BARKER.

A. B., a woman aged 33, has an eruption on the trunk of three weeks' duration. Most of the lesions developed within a week and have shown no tendency toward involution. The lesions itch slightly. The patient underwent cholecystectomy five years ago.

Examination shows on the trunk many over-topped raised firm yellow lesions, varying in size from that of a pinhead to that of a split pea and having smooth and glistening surfaces. There is no surrounding erythema, and the lesions are not tender on pressure. There are a few scattered lesions on the arms and in the axillae. The mucous membranes are not involved.

Chemical examination of the blood showed 110 mg. of sugar, 8.7 mg. of urea, 3.2 mg. of uric acid and 190 mg. of cholesterol. Examination of the urine and the sugar tolerance test showed no abnormality. Histologic examination showed an infiltration of the corium by large, somewhat pale cells which were pressed together and were suggestive, though not characteristic, of xanthoma cells. It was noted in the histologic report that the ultimate correctness of the diagnosis was dependent on the application of a lipoid stain.

The treatment has consisted of curetting the lesions, a few at a time, with the area anesthetized with ethyl chloride. The patient is on a fat-free diet.

DISCUSSION

DR. CHARLES WOLF: It may be well to recall a patient presented ten years ago by Dr. B. Berkowitz, a child with generalized xanthoma. The patient was presented again at a subsequent meeting as completely cured. The drug used was a homeopathic remedy, a preparation of palladium. I do not know the dosage. It would be worth trying in this case.

DR. J. GARDNER HOPKINS: The technic of cholesterol determinations has been thoroughly revised since the work of Schoenheimer. Determinations by former methods were considered unreliable. I do not think the technic used at present has been criticized.

DR. FRANK C. COMBES: I wanted to ask a question about the significance of determinations of cholesterol in these cases. A form of treatment with which I have had no personal experience in cases of multiple xanthoma but which is reported on favorably in the literature is that of elimination of milk, milk products, eggs, meat, fish and fats from the diet. In addition to this, generalized irradiation is administered from the air-cooled quartz mercury vapor arc lamp.

DR. SIGMUND POLLITZER: It is generally accepted that there is a high cholesterol content in the blood in cases of generalized xanthomatosis. There is this to be said, however: It is not necessary that there be a high cholesterol content at any one time. It is perfectly possible that there may have been a high cholesterol content in the blood, resulting in the deposit of cholesterol and of fatty acid esters in the tissues, at some previous time. These deposits remain and are not readily absorbed. When the condition that produced the high cholesterol content in the blood has disappeared, there may be a fairly normal cholesterol value. I think that point should be remembered. Extensive cholesterol deposits are not present in the skin or other tissues without there having been a high cholesterol content in the blood. I think that is perfectly obvious.

DR. A. W. GRACE: I think there is one point which ought to be stressed in regard to recording observations on the chemical content of the blood. There should be a record of whether the determination has been on the serum, the plasma or the whole blood. When one reads that the cholesterol content is 190 mg., one does not know on which of these three materials the estimation has been made. Another point which should be mentioned is the type of anticoagulant used. When one uses sodium citrate, one gets different results than when one uses hirudin or potassium oxalate. The third point to be indicated is the name of the method employed for the determination.

DR. LESLIE PAXTON BARKER: There does seem to be a difference between the cholesterol readings of different laboratories. At one hospital I was informed

that the high normal reading for blood cholesterol is 250 mg., while at another laboratory the high normal reading is 150 mg., and one of 190 mg. would be considered much too high.

A Case for Diagnosis (Ulerythema Ophryogenes? Neurodermatitis Decalvans?). Presented by DR. MARION B. SULZBERGER.

N. K., a man aged 29, is presented because of an eruption of over eleven years' duration on the forehead and the face. The dermatosis consists of dryness, thickening of the skin, slight erythema and scaling and is located on the forehead, the eyebrow areas and the cheeks, being more marked on the left side. Scattered throughout the affected areas there are slightly elevated hard, elastic nodules, the size varying from that of a pinhead to that of a small pea. There is definite alopecia of the eyebrows and the bearded area. In the latter the alopecia is similar in configuration to that seen in alopecia areata.

All investigations, including blood counts and cutaneous tests, have given normal results. Two histologic examinations offered no clue to the diagnosis, except that one examination suggested early lupus erythematosus. It is to be emphasized that the eruption is not pruritic, and the patient states emphatically that he does not scratch it. The dermatosis has resisted all forms of therapy attempted, including twelve treatments with ¼ skin unit of unfiltered roentgen rays.

DISCUSSION

DR. SIGMUND POLLITZER: Ulerythema is virtually lupus erythematosus of the eyebrows, and I must say that I was not impressed with the validity of that diagnosis in this particular case. There is no explanation offered for the widespread erythema, which involves the entire forehead and part of the face. I do not know what produced that condition, and there is no indication in the history. Altogether, I should hesitate to accept the diagnosis of ulerythema ophryogenes, but I have no other diagnosis to propose.

DR. FRANK C. COMBES: I agree with the latter statement made by Dr. Pollitzer but not with the former. I have never heard ulerythema ophryogenes interpreted as lupus erythematosus of the eyebrows. I had always considered it more or less identical with ulerythema sycosiforme or lipoid sycosis.

Report on a Case of Pityriasis Rubra Pilaris. DR. MAX SCHEER.

R. G., a boy aged 10 years, was previously presented at a meeting of the New York Academy of Medicine, Section of Dermatology and Syphilis, on Feb. 2, 1937 (ARCH. DERMAT. & SYPH., this issue, p. 1250).

The diagnosis of pityriasis rubra pilaris has been confirmed since the presentation by microscopic examination.

Lichen Planus (Annular, Atrophic Form). Presented by DR. HENRY D. NILES.

Psoriasis. Presented by DR. GEORGE M. LEWIS.

Psoriasis. Presented by DR. EUGENE F. TRAUB.

Naevus Unius Lateris. Presented by DR. GEORGE M. LEWIS.

Lupus Erythematosus. Presented by DR. HENRY D. NILES.

Dermatitis Medicamentosa (Phenolphthalein). Presented by DR. HARRY C. SAUNDERS.

PITTSBURGH DERMATOLOGICAL SOCIETY

JOSEPH J. HECHT, M.D., *President*

Feb. 18, 1937

ABRAHAM FISHER, M.D., *Secretary*

Keratoderma Plantare. Presented by DR. W. H. GUY and DR. F. M. JACOB.

A. S., an Italian woman aged 40, complains of thickening of the skin of the left toes and heel. This has been present for several years. Improvement has frequently occurred after the administration of thyroid, and the condition has promptly recurred when this medication has been stopped.

There are large areas of hyperkeratosis on the inner side of the heel and behind the great toe of the left foot.

DISCUSSION

DR. LESTER HOLLANDER: This patient is in the period of life during which women are subject to keratoderma climactericum.

DR. F. M. JACOB: I observed three cases like this one at the Pittsburgh Hospital. Two patients were nuns. One of them had rheumatic iritis accompanying the keratoderma and was given thyroid for the iritis. The keratoderma disappeared with the iritis.

Unusual Case of Secondary Syphilis. Presented by DR. ARTHUR WINFIELD GLICK, Homestead, Pa.

M. F., a white man aged 22, consulted a physician on Dec. 2, 1936, because of enlarged inguinal glands. The physician prescribed 30 drops of potassium iodide three times a day. Three weeks later an eruption developed. The Wassermann reaction was 4 plus.

The patient presents discrete cherry-red anulopapulosquamous lesions, varying in size from that of a pea to that of a quarter, on the scalp, the face, the scrotum, the body and the legs. Some are elevated and others depressed, and there is some atrophic scarring. On the left tonsil and in the area around the right upper incisor are annular lesions. Cervical and inguinal adenopathy are present. When the patient was first seen, many lesions were pustular and had the appearance of pustular iododerma.

DISCUSSION

(All agreed with the diagnosis.)

Pemphigus. Presented by DR. ABRAHAM FISHER, McKeesport, Pa.

T. B., a white man aged 60, noticed an irritation of both eyes nine months ago. This became progressively worse until there was general reddening of the conjunctivae, with lacrimation.

Seven months ago his mouth began to be irritated, and the mucous membrane started peeling.

Eighteen months ago he injured his nose, and an ulcer began at the left nasolabial portion and spread over the tip to the corresponding area on the right side of the nose. This lesion cleared with injections of a bismuth preparation.

Examination shows conjunctivitis of both eyes and lacrimation. Both lower eyelids are adherent (symblepharon). There are several denuded areas on the palate, the upper alveolar ridges and the adjointing buccal mucous membrane. There is a thin scar on the nose, where there had been a serpiginous ulcer.

Hematologic examination showed nothing of interest; there were no serologic changes, and the phytopharmacologic test gave a result of 60 per cent.

DISCUSSION

(All agreed with the diagnosis.)

NEW YORK DERMATOLOGICAL SOCIETY

H. H. WHITEHOUSE, M.D., *Presiding* in the absence of

PAUL E. BECHET, M.D., *President*

Feb. 23, 1937

EUGENE F. TRAUB, M.D., *Secretary*

A Case for Diagnosis (Ichthyosis Hystrix?). Presented by DR. FRED WISE.

J. W., a boy aged 2 years, was first seen on Jan. 28, 1937, with an eruption on the trunk, the face and the extremities which had been present since birth. The patient was born with white skin which was thicker than normal. It was so itchy that from the first few months of life the hands had to be tied to prevent scratching. The skin has become more pigmented and thick, especially on the palms and the soles. There is no history of consanguinity in the family; four older sisters are living and well.

The entire body except the face is covered with confluent brownish black hyperkeratotic lesions, which in places have been scratched off, showing erythematous areas; the underlying skin is coarser than normal. The eruption is more advanced on the palms and the soles than elsewhere, and the hyperkeratotic lesions are more raised. The forehead, the tip of the nose and the upper lip show erythematous patches, and the cutaneous papillae here appear normal. The toe-nails are thin and dystrophic with the concavity upward. The finger-nails are in better condition; several have recently fallen off, and new ones are now growing. There has been some removal of the hyperkeratotic process with the use of 6 per cent salicylic acid in boric acid ointment.

DISCUSSION

DR. R. H. RULISON: I agree with the diagnosis.

DR. A. BENSON CANNON: I think that this case is one of congenital ichthyosiform erythroderma. There is a certain amount of redness, and the condition is unquestionably ichthyosis.

DR. EUGENE F. TRAUB: I do not believe there is enough erythroderma in this case for it to be grouped among cases of erythroderma congenitale ichthyosiform. Is it proper to call such a condition ichthyosis hystrix? The eruption is absolutely symmetrical. Is it a hypertrophic warty type of ichthyosis?

DR. H. H. WHITEHOUSE: I am inclined to agree with those who did not see any erythroderma.

DR. EUGENE F. TRAUB: Ichthyosis hystrix is always a nevus, is it not?

DR. FRED WISE: I believe the proper designation for this type of nevoid eruption is ichthyosis hystrix. Presumably it is always a nevus, but it does not have to be unilateral. It can be symmetrical and bilateral and still be that disease.

A Case for Diagnosis (Seborrheic Keratoses?). Presented by DR. JOSEPH J. ELLER.

W. J., a woman aged 27, of Norwegian descent, was previously presented before this society in October 1936 (ARCH. DERMAT. & SYPH. **35**:1191 [June] 1937), at which time a diagnosis of seborrheic keratoses was offered by several members.

Biopsy specimens were examined by Dr. Fred Weidman, and on Nov. 18, 1936, he reported: "In the corium there is nothing really distinctive, and I think that urticaria pigmentosa can be pretty definitely excluded. I wonder, though, whether the clinical features can be reconciled with the picture of subclinical Darier's disease—a forme fruste, as it were."

On Dec. 15, 1936, urinalysis revealed distinct evidence of the presence of bromides. There was no history of ingestion of bromides other than the admission of the patient that she had taken small amounts of "bromoquinine" in January 1936 and a cough medicine, "rem," two years ago. The patient was treated with sodium chloride, 10 per cent solution, both intravenously and orally. On Jan. 14, 1937, the tests for iodides and bromides gave negative results. In February 1937, there were observed in the right temporal and the left scapular region new lesions, which were maculopapular, varied in size from that of a dime to that of a nickel and were lightly pigmented and covered with a fine scale. The Wassermann reaction has always been negative.

DISCUSSION

DR. FRED WISE: I should make a diagnosis of late verrucous pigmented nevi. I think these lesions come out late in life and really belong to the nevus family.

DR. A. BENSON CANNON: While I am not thoroughly satisfied with the diagnosis of seborrheic keratoses, I admit that many of the lesions do look remarkably like seborrheic warts. I do think the picture would fit in with that of a bromide eruption more closely than with that of seborrheic keratoses. The patient has no seborrhea in the scalp at the moment and no lesions around the waist and on the back, areas where the condition may be expected. I agree with Dr. Wise that she does show many nevi on the back and the chest, but I do not think they are to be confused with those lesions she has on the face. I think the two conditions are different.

DR. R. H. RULISON: This girl has a great many undoubted nevi. There is no question about that. I think the lesions for which she is shown are distinct from the birth marks she has. I think they belong in some other group, and since bromides were found at one time in the urine, I think their presence will have to be excluded as the cause.

DR. EUGENE F. TRAUB: Today I had a good chance to examine this patient in the daylight. At the last meeting I had no diagnosis to offer, but in better light I had no doubt that she had two different types of lesions. She had a number of nevi on the upper part of the trunk, in addition to the lesions on the face, which were the main reason for the presentation. The facial lesions are on an inflammatory base and are covered with a firmly adherent scale. I do not see why one cannot make a diagnosis of seborrheic keratoses, especially in view of the histologic observations. I suggest to Dr. Eller that he try a small dose of roentgen irradiation, that is, just a little over an erythema dose, unfiltered, to see if the lesions do not disappear. Dr. Eller pointed out that when bromides were found in the urine and then eliminated by injections of sodium chloride, it had no influence on the appearance of new lesions. New lesions have appeared since then. These facts would, in my opinion, exclude bromides as a cause.

DR. H. H. WHITEHOUSE: I should be inclined to look on this condition as a mixed eruption. The patient has many nevi on the body. While her scalp is clear now, she confessed that seborrhea had long been present on the scalp. I think, as Dr. Traub does, that the effect of bromides can be excluded. I am inclined to believe the condition is seborrhea.

DR. FRED WISE: I should like to call attention to the fact that the urine of all persons who eat rye bread might show bromides. Rye bread contains bromates. I do not think the finding of bromides has any significance for persons who eat rye bread, unless one obtains a quantitative estimate.

DR. JOSEPH J. ELLER: I cannot reconcile myself to the fact that these lesions are seborrheic keratoses, as new ones appeared so suddenly while the patient was under observation. I was surprised to find bromides in the urine. However, after the bromides were eliminated, new lesions appeared. The patient gives absolutely no history of having taken bromides.

A Case for Diagnosis (Solid Edema of the Face?). Presented by Dr. Joseph J. Eller.

C. C., a man aged 22, presents edema of both periorbital regions that began about thirteen years ago after an acute inflammatory eruption of the face and the head which was at that time diagnosed as erysipelas. With the exception of one or two days occasionally the periorbital edema is persistent. The patient has undergone tonsillectomy, adenoidectomy, and drainage of both antrums, dacryocystotomy seven years ago and an incision at the root of the nose (for tear ducts) six years ago. He has had constant medical attention for the past four or five years, including numerous scratch tests, weekly ultraviolet irradiation and injections. The patient states that the edema becomes more severe every spring and summer, that these changes are frequently accompanied by an eczematous eruption of the face and that when he has an attack of grip he notices that the edema recedes somewhat.

DISCUSSION

Dr. Fred Wise: I do not know what to do for a patient with this disease, aside from roentgen irradiation. I know that the streptococcus is said to be the cause of the trouble, and injections of streptococcus vaccine are supposed to be of benefit. However, I have never seen a single instance in which such injections have helped the disease; on the other hand, I can recall two instances in which roentgen therapy proved curative.

Dr. R. H. Rulison: My understanding was that in most of these cases the condition slowly clears over four or five years.

Dr. A. Benson Cannon: I am surprised that this man should have so many recurrent attacks over such a long period without sclerosis. This condition is soft edema, more like a lymphatic stasis than anything else. I should prefer ultraviolet rather than roentgen irradiation, as suggested by Dr. Wise. I think ultraviolet irradiation is more or less foolproof, and it would accomplish better results. I should also consider baking and massage. I think the condition is sufficiently severe to warrant some radical change in his treatment, because the treatment he has had so far has been of no benefit.

Dr. J. Gardner Hopkins: Dr. Stevens has been much interested in cases of this type, and he has found that some patients react to streptococci and some to staphylococci. Those I have seen have been divided about half and half. I have thought that injection of the toxin, if it is the right one, usually stops the acute attacks, and then there remains edema, which may or may not decrease. This patient has been treated by Stevens for some time without any improvement. Some of the patients have no demonstrable lesions in the nose. A patient I have now has a recurrent fissure. By destroying such lesions, one can often prevent subsequent attacks. Another interesting possibility which Dr. Cannon brought up is that some of those operations on the nose may have blocked the lymphatics—that the process is not infectious at all but may possibly be the result of treatment.

Dr. Eugene F. Traub: It would seem that the main issue to decide is whether the edema is due to a mechanical blockage or to infection. When this has been determined, therapy in the future may be intelligently outlined. There is a patient now at the Skin and Cancer Unit of the New York Post-Graduate Medical School and Hospital who was sent by Dr. Hopkins. While waiting for a report of previous treatment my associates and I gave the patient an injection of manganese butyrate, and he claimed that this produced the first decided improvement he had had from any form of therapy. Later he had a relapse; we gave one or two more injections, and the condition eventually cleared. Whether this was due to the therapy or not, I do not know. In another case the condition apparently cleared after administration of bacteriophage. If the causative organism in this case is the streptococcus, as Dr. Hopkins suggested, maybe dyes would so some good.

A Case for Diagnosis (Dermatitis Factitia?). Presented by Dr. Joseph J. Eller.

F. K., a man aged 45, presents on the dorsum of the right hand and on the fingers eight round, punched-out, deeply excavated ulcerations of varying sizes and configurations. The distribution of the lesions is somewhat bizarre, as is the configuration of the borders. The edges of each lesion are raised, infiltrated and sharply defined. The floor of the ulceration is covered with granulation tissue. Several other areas show bizarre configurations. The patient states that while he was testing a boiler, in October 1933, steam containing "a compound" produced a first degree burn of the right hand. Weeping vesiculo-erythematous dermatitis ensued and appeared unresponsive to treatment with ultraviolet and roentgen radiation and silver nitrate. In March 1936 splints were applied and the hand was bandaged for six months. The patient states that all lesions had practically healed at the end of this time, but reappeared soon thereafter and were again treated with roentgen radiation. The exact number of treatments is unknown, but he believes that a total of about fifteen treatments was received. All the finger-nails fell out during roentgen therapy, and only three reappeared normally. The patient insists that he has never changed bandages or applied local treatment himself, but he has seen a physician at least three times weekly since 1933. His general health is good.

DISCUSSION

Dr. Fred Wise: I think the eruption on the hand is the scar from an old burn with superimposed erosions caused by chromium trioxide. Those lesions, in my opinion, are typical effects of chromium trioxide.

Dr. A. Benson Cannon: I agree with the diagnosis of dermatitis factitia. I have seen many acute and subacute burns caused by chromium trioxide used in the preparation for operation or applied as a therapeutic agent, and I have not seen such deep sloughing and eschars as are presented by this patient. I have recently treated a man who showed ulcerations on the back of the right hand which were identical in every respect with those seen in the patient presented tonight, and it was proved that the wounds were inflicted with nitric acid.

Dr. R. H. Rulison: I agree with the diagnosis.

Dr. Jerome Kingsbury: I agree with the diagnosis of dermatitis factitia.

Dr. J. Gardner Hopkins: So-called holes in workers with chromium trioxide are chronic ulcers. I have seen only one such condition, in a man whose occupation involved the use of chromium trioxide. That condition usually requires much more prolonged use of the acid than had occurred in this case. I think the condition is dermatitis factitia.

Dr. Eugene F. Traub: The history in this case was that the patient was under a physician's constant care and that this physician was applying a solution of silver nitrate to these lesions. Then, when a crust formed, the physician removed it and repeated the application. The term dermatitis factitia is generally looked on as implying that the patient is responsible for the artificial nature and appearance of his condition. For this reason I believe this term should be modified to indicate that the treatment given by the physician, rather than malingering on the part of the patient, was responsible for the condition.

Dr. Joseph J. Eller: I do not know the type of chemical which the patient used in his occupation. I have observed erosions from chromium trioxide, but they did not look punched out like these.

A Case for Diagnosis (Pemphigus?). Presented by Dr. Fred Wise.

V. B., a man aged 37, a physician, is presented for Dr. J. Frank Fraser. The patient was first seen on Jan. 9, 1937, with an eruption of four months' duration. Two years ago the patient had impetigo contagiosa (?) of the scalp, which lasted

about one month. He was treated with three ⅛ skin unit doses (38 r) of roentgen rays, which cleared the eruption of the scalp. Four months ago the eruption recurred and spread to the shoulders. About two months ago the patient had a seizure of grip, and then the lesions spread to the back and the front of the chest and the abdomen. The extremities were comparatively free. Subjective symptoms were burning and itching, which disturbed his sleep.

The lesions started as pea-sized denuded patches of epidermis without underlying erythema and later acquired an erythematous base and became slightly elevated. Some of the lesions were clear vesicles and small bullae. Medication consisted of oral and intravenous administration of sodium thiosulfate, intramuscular injection of sodium arsenate and oral administration of plasmoquin. Superficial roentgen therapy was given to the trunk and the scalp.

Histologic examination resulted in a diagnosis of probable pemphigus. A complete blood count was within normal limits.

NOTE.—The diagnosis of pemphigus was confirmed on further observation.

DISCUSSION

DR. A. BENSON CANNON: At first glance I thought of pemphigus, but on closer inspection I should be inclined to look for some other cause for the condition. The man's good physical condition and his facies are not those of a patient with pemphigus. He has no lesions of the mucous membranes. If the condition is pemphigus, it is of the most benign type. I should consider bullous erythema multiforme, Duhring's disease or possibly a drug eruption—at least one of the less serious maladies.

DR. R. H. RULISON: I do not think the condition clinically resembles pemphigus. I have no diagnosis to offer.

DR. EUGENE F. TRAUB: The lesions on the chest and the back strongly suggest the Senear-Usher type of pemphigus. On the other hand, the lesions on the scalp, in the axilla and around the genitalia are much more like pemphigus vegetans. If this condition turns out to be pemphigus vegetans, the prognosis is rather bad. I should like to have Dr. Wise's opinion as to whether he thinks it will be pemphigus vegetans. I agree that it is a type of pemphigus.

DR. H. H. WHITEHOUSE: I am rather inclined to the opinion expressed by Dr. Cannon, that this condition is bullous erythema multiforme, Duhring's disease or something of that sort. There is nothing in the mouth. Pemphigus vegetans has proved to be a rather rapid and destructive process in my experience. I should think this is not pemphigus.

DR. JOSEPH J. ELLER: I have no diagnosis to offer. I do not think this case is one of pemphigus.

DR. FRED WISE: Dr. Fraser asked me to present this case as one of pemphigus, and he based that diagnosis largely on the histologic examination. Senear and Usher described lesions in this disease which began in the form of impetigo, seborrheic eczema, erythema multiforme and so forth. As time goes on, the lesions sometimes become pemphigoid, and true pemphigus vulgaris or perhaps pemphigus vegetans frequently develops later. That occurrence has been described in a number of articles, and it seems there is some foundation for such a diagnosis as Dr. Traub mentioned. My personal opinion is that this patient has pemphigus.

Cutaneous Calcinosis. Multiple Telangiectasia. Presented by DR. EUGENE F. TRAUB.

S. R., a woman aged 36, was previously presented at a meeting of the Brooklyn Dermatological Society in February 1931 (ARCH. DERMAT. & SYPH. **24**:470 [Sept.] 1931). Since the previous presentation the lesions have grown slowly but progressively worse. She has considerable pain in the finger, the area chiefly

involved. Roentgen examination showed an osteoid type of calcification over the terminal tuft of the left middle finger and further calcification of the subcutaneous tissues of the lower ends of the forearms.

Chemical examination of the blood showed 70 mg. of sugar, 145 mg. of cholesterol and 10.4 mg. of calcium (as Ca) per hundred cubic centimeters of blood.

Histologic examination of a biopsy specimen showed the following: The section was difficult to examine because of its extreme calcification. A portion of the specimen examined qualitatively was found to consist of calcium carbonate and calcium fatty acids.

In addition to the cutaneous calcinosis, for which, chiefly, the patient is presented, she shows a large number of spider nevi scattered over the face, the neck and the upper part of the trunk. These lesions are apparently an entirely independent nevoid condition.

DISCUSSION

DR. FRED WISE: I agree with the diagnosis and should like to ask whether any roentgenograms have been taken of the shins or other long bones to see if there are any deposits of calcium in the soft tissues.

DR. H. H. WHITEHOUSE: I agree with the diagnosis of calcinosis. The picture seems to be characteristic.

DR. EUGENE F. TRAUB: This case was accepted as one of cutaneous calcinosis at the previous presentation, six years ago.

Lichen Planus with Atrophic Papules. Presented by DR. FRED WISE.

R. V., a girl aged 20, unemployed, born in the United States, was first seen on Feb. 6, 1937, with an eruption which had been present for three and a half months on the right side of the neck and the upper portion of the right shoulder. The eruption was preceded by itching of one day's duration.

There is a circumscribed rectangular patch of erythematous papules just above the right clavicle and extending to the midline, where it ends abruptly. The patch has a reticular appearance, the center of the reticulum having apparently normal skin and the periphery being formed by pinhead-sized depressed and atrophic papules. On the upper part of the right shoulder is a similar lesion in which the papules are more discrete. In the patches the papules are flat tipped, shiny, polygonal and pinhead sized. The anterior lesion shows a group of circinate formations.

Histologic examination showed lichen planus of the pigmented and bullous variety.

DISCUSSION

(The members agreed unanimously with the diagnosis of lichen planus.)

Lupus Erythematosus. Presented by DR. FRED WISE.

R. B., a married woman aged 52, was previously presented before the New York Dermatological Society on Nov. 24, 1936 (ARCH. DERMAT. & SYPH. **36**:384 [Aug.] 1937), with a diagnosis of tuberculosis verrucosa cutis of the left hand and the left foot and lupus vulgaris of the right side of the face and the scalp. Further observation revealed that the previous diagnosis was erroneous. Topical treatment resulted in partial removal of hyperkeratotic deposits on all lesions, and it became evident that the facial eruption was lupus erythematosus associated with pronounced atrophy, while the solitary lesions on the extremities proved to be the hyperkeratotic variety of the disease. All the lesions exhibited considerable improvement after four injections of gold sodium thiosulfate had been administered.

DISCUSSION

DR. R. H. RULISON: The picture is entirely different now, as I remember it, from that observed at the previous presentation. I think the present diagnosis is probably correct.

DR. EUGENE F. TRAUB: I believe I looked on this eruption as eczema before, and I still think the patch on the foot looks more like eczema than anything else. I hope Dr. Wise will keep the members informed on the progress in this case.

DR. JOSEPH J. ELLER: I think this condition is on the borderline, clinically resembling lupus erythematosus and, on account of the color, possibly being lupus vulgaris. I should think that the quick response to gold sodium thiosulfate would indicate a diagnosis of lupus erythematosus.

DR. H. H. WHITEHOUSE: I agree with the diagnosis of lupus erythematosus. The effect of gold on the eruption seems to point that way.

DR. FRED WISE: Three biopsy specimens were taken from this patient—from the scalp, from the foot and from the hand—and the questionable diagnosis of keratosis blennorrhagica was submitted by the histologist. It is known that that disease is not present, but the histologic examination at least excludes eczema. At all events, the eruption is improving under treatment with a gold compound, and I will report the future progress at the next meeting.

NOTE.—Further observation confirmed the diagnosis of lupus erythematosus.

A Case for Diagnosis (Lichenoid Dermatitis? Lichen Planus?). Presented by DR. FRED WISE.

I. M., a Negress aged 42, was first seen on Feb. 4, 1937, with a generalized eruption of nine weeks' duration. Two and one-half months ago the patient first noticed itching on the neck. Gradually the itching spread to other parts of the body, and pigmented, slightly scaly lesions appeared on the neck, the trunk, the arms and the legs. Itching has continued up to the present time. There is no history either of injection or of ingestion of arsenic.

The patient presents a widespread eruption consisting of irregular pigmented lesions, in many places coalescing. There is slight peripheral scaling about these lesions, and a suggestion of atrophy in the center. In addition, on the forearms, there are scattered lichenoid lesions. However, there are no lesions typical of lichen planus. The mucous membranes are unaffected.

A complete blood count showed no abnormality. The results of a Wassermann test of the blood have not yet been reported. Histologic examination showed pigmented lichenoid dermatitis, "which would fit in with the diagnosis of dermatitis toxica lichenoides of Riehl."

NOTE.—The diagnosis of lichen planus was confirmed by further observation. The Wassermann reaction was negative.

DISCUSSION

DR. A. BENSON CANNON: As the possibility of syphilis has been ruled out in this case, lichen planus has to be considered. Whether lichen planus is produced by a drug or by something else, I do not know. In this case there are many annular lesions with raised, threadlike borders and numerous white striations on the back, which confirm my suspicion of lichen planus. Histologic specimens taken from along the borders of these lesions would present a different picture from that presented by specimens from the center. I favor the diagnosis of lichen planus.

DR. EUGENE F. TRAUB: I agree exactly with what Dr. Cannon has said. I believe this case is one of lichen planus.

DR. H. H. WHITEHOUSE: I think the condition is more likely lichen planus than anything else.

DR. FRED WISE: I am inclined to agree with the diagnosis of lichen planus, especially in the absence of any history of injection or ingestion of drugs and of absolutely any evidence of intravenous injections. I examined the antecubital veins carefully for traces of needle marks and found none.

A Case for Diagnosis (Psoriasis?). Presented by DR. FRED WISE.

M. L., a fireman aged 63, born in Russia, was first seen on Feb. 23, 1937, with a generalized eruption of five months' duration. The eruption began in September 1936 on the flexor aspect of each forearm and spread within two months to involve practically the entire integument. There has been no change in the type of lesion constituting the eruption since its development.

Examination shows an eruption involving the face, the trunk, the upper and lower extremities, the penis and the dorsa of both hands and feet. The scalp and the ears are practically free from lesions. Individual lesions vary in size from those of a diameter of ¼ inch (0.6 cm.) to confluent areas roughly 5 inches (12.5 cm.) square. The smaller lesions are best seen on the anterior aspects of the chest and the abdomen, where some are grouped in roughly circular formation. The larger lesions occupy the lateral aspects of the chest and the upper and inner parts of the thighs. The primary lesion is a slightly raised firm erythematous nodule covered with readily detached fine scales, which are not silvery and do not leave bleeding points on removal. There is only slight pruritus. The nails are not involved, nor are there any lesions on the buccal or the lingual mucosa. There is no lymphadenopathy, and the patient, although a little overweight, is in good physical condition.

NOTE.—Histologic examination showed psoriasis. A complete blood count was within normal limits.

DISCUSSION

DR. R. H. RULISON: I thought this eruption was probably mycosis fungoides.

DR. JOSEPH J. ELLER: From its clinical appearance, I think the diagnosis of mycosis fungoides should be first considered.

DR. A. BENSON CANNON: I think mycosis fungoides is a likely explanation for this dermatosis. Any pruritic cutaneous disease of two years' duration resulting in nodules (in the absence of glandular enlargement or any other evidence that would point to a condition of the lymphoblastoma group) should be suspected of being mycosis fungoides.

DR. EUGENE F. TRAUB: I am in accord with the diagnosis of mycosis fungoides.

DR. H. H. WHITEHOUSE: The patient has a number of infiltrated lesions, and they conform to the clinical picture of mycosis fungoides more than to any other picture I can think of.

DR. FRED WISE: I agree with the diagnosis of mycosis fungoides and will present the histologic report at the next meeting.

A Case for Diagnosis (Psoriasis?). Presented by DR. FRED WISE.

E. K., a boy aged 18, a clerk, born in the United States, was first seen on Jan. 30, 1937. The eruption began in June 1936 with itching lesions on the posterior aspects of both soles. The patient states definitely that there were no blisters on the feet in the beginning. The eruption soon spread over the inner aspects of both feet but never involved the interdigital areas. One month later, when the right arm was in a plaster cast after a fracture of the humerus, the patient noticed a scab on the posterior aspect of the right arm, apparently from irritation of the cast. He picked the scab and found that a lesion similar to that on the foot was developing. This was somewhat itchy but not as much so as the lesions on the feet. Since then, lesions have appeared elsewhere on the trunk and the limbs and are continuing to do so. Itching has practically disappeared now, from the new lesions as well as from the original lesions.

Examination shows numerous circumscribed scaly dry erythematous lesions on both arms, the root of the neck, the upper part of the chest, the back, the palms and the soles. The face and the scalp are unaffected. The scales are large and are not silvery white like those in psoriasis. On removal they do not leave bleeding points. The lesions vary in size from those of a diameter of 1 inch (2.5 cm.)

to an involvement of practically the whole upper portions of the arms. The configuration of the smaller lesions is usually oval, and no lesion is smaller than 1 inch (2.5 cm.) in diameter. There are no lesions between the toes. The general health is excellent.

The histologic examination showed a long-standing toxic dermatitis. Scrapings from the hands, the feet, the back and the arms did not show fungi either in a wet preparation or on culture. Intradermal tests with trichophytin gave negative results.

DISCUSSION

DR. A. BENSON CANNON: I should always think of psoriasis in diagnosing any obstinate dry type of scaly eruption which is erythematous and in plaques and which involves, as this does, the soles and, I believe, the palms, with pitting of the nails. I cannot fit the picture in with anything which is more plausible.

DR. EUGENE F. TRAUB: This case does not impress me as one of psoriasis. The boy's feet certainly suggest the possibility of a tinea infection, although, I understand, he has been carefully studied from this standpoint and the results of the study have been negative. Occasionally such negative results do not absolutely exclude the possibility of tinea. I should be inclined to make further mycologic studies. The patient gave a history of taking ex-lax occasionally, and a phenolphthalein eruption might possibly account for the lesions on the trunk. Some such diagnosis would seem more suitable than one of psoriasis.

DR. H. H. WHITEHOUSE: The eruption conforms more to the picture of psoriasis, as Dr. Cannon said. I have seen psoriasis confined to the soles. I should be inclined to regard this as psoriasis, although the lesions on the body are superficial.

DR. JOSEPH J. ELLER: I agree with Dr. Cannon's interpretation of the case. I think the lesions of the soles have the color of psoriasis. However, the lesions on the trunk and the upper part of the chest, while they may have the color, do not show the characteristic scaling. I feel, as Dr. Cannon does, that the possibility of psoriasis must be ruled out.

Dermatitis Factitia. Presented by DR. FRED WISE.

M. K., a girl aged 16, a student, born in the United States, was first seen on Jan. 19, 1937, with an eruption on the neck and the shoulders. In the early part of January 1937 the patient felt her throat to be sore and complained that food could not be swallowed. A few days later, on January 7, she had aches and pains "all over the body," with considerable abdominal pain and some vomiting, for which no reason could be assigned. On the same night she complained of "burning all over" and called her mother, who found a large blister on the back of the neck, 7½ inches (19 cm.) long and 1½ inches (3.8 cm.) broad, looking like a collar. Within a few hours the skin "fell off" the blister, leaving a raw surface. Similar lesions appeared simultaneously on the lower outer aspect of the upper part of the right arm, the left shoulder, the right shoulder near the angle of the scapula and the outer aspect of the upper part of the left arm. The patient remained at home until Jan. 19, 1937, when she was first seen in the clinic. During that period there was considerable pain at the site of the lesions, and the sore throat previously complained of gradually cleared. Examination on January 19 showed raw areas, extremely painful and closely resembling ruptured bullae, on the sites previously mentioned. These lesions were treated with boric acid ointment and have gradually improved. Since the first examination new lesions have appeared.

On February 4 an area the size of a half-dollar on the lower outer aspect of the upper part of the right arm became hard, painful and erythematous. Pain in this area increased during the next twenty-four hours while the patient was under her mother's observation, and finally a bulla arose on the site, identical with those noticed in the earlier lesions. The whole right arm and the joint of the elbow were considerably swollen for five days, during which time pus was seen to exude from

the new lesion. On examination on February 13 the lesion on the right arm had cleared and showed a small ulcer in the center, from which serous fluid could be expressed. The earlier lesions were healing well. The eruption was evidently self inflicted and appeared to be due to cauterization with an acid. Persistent questioning of the patient and of her mother gave no clue as to the origin of the dermatosis.

The patient was examined in the psychiatric clinic and was reported to show no psychic abnormalities.

DISCUSSION

DR. EUGENE F. TRAUB: If I recall, the last time I saw this patient at a staff meeting she smelled quite strongly of phenol or saponated solution of cresol. When I questioned her about the odor she explained that she had applied phenolated petrolatum to the lesion. I suggest that Dr. Wise recheck that story, however.

DR. H. H. WHITEHOUSE: I agree with the diagnosis as presented. While the motive has not been revealed and the psychiatrist has helped none in the matter, it seems to me from the behavior of the child and the mother that the patient is just the type of person to produce these self-inflicted lesions.

(Drs. Joseph J. Eller, R. H. Rulison and A. Benson Cannon agreed with the presenter's diagnosis.)

Report on a Case of Erythroderma. Dr. Fred Wise.

F. R., a woman aged 57, was presented before the New York Dermatological Society on Jan. 26, 1937 (ARCH. DERMAT. & SYPH. **36**:893 [Oct.] 1937), with an eruption on which a tentative diagnosis of erythroderma, possibly of the type preceding mycosis fungoides, was made.

Histologic examination showed the eruption to be leukaemia cutis. Three sections were examined, all of which confirmed the diagnosis of that form of lymphoblastoma.

PAUL E. BECHET, M.D., *President*

March 23, 1937

EUGENE F. TRAUB, M.D., *Secretary*

Epidermolysis Bullosa. Presented by DR. FRANK C. COMBES.

N. S., a boy aged 15, was presented before the New York Dermatological Society in November 1928 (ARCH. DERMAT & SYPH. **19**:701 [April] 1929.

Since the previous presentation the patient's condition has gradually become worse, there being no tendency toward improvement with the onset of puberty. Recently his finger-nails and toe-nails have atrophied, two of the former having disappeared entirely.

Livedo Reticularis. Presented by DR. HOWARD FOX.

J. C., a woman aged 26, has suffered all her life from poor circulation. She presents marked passive congestion of the extremities of the livedo reticularis type. From the shoulders to the wrists and from the hips to the ankles, on the entire surface of the limbs, there are innumerable coalescing bluish red rings varying in size from that of a 5 cent piece to that of a half-dollar. Her skin is normal otherwise. Her hands present the diffuse type of passive hyperemia, being bluish red, cold and clammy. She is well nourished and in general good health, though the Wassermann reaction was 3 plus. She has been married eight years and had one stillborn child one year after marriage. She has not since been pregnant. The Wassermann reaction probably represents an acquired

infection, as she shows no stigmas of congenital syphilis. Five months ago she had a severe attack of bullous erythema multiforme, which required hospitalization for six weeks.

DISCUSSION

DR. FRED WISE: Ehrmann's livedo racemosa may be a symptom of acquired syphilis.

DR. HOWARD FOX: I do not think the eruption has the slightest relation to syphilis. The patient has always had poor circulation.

A Case for Diagnosis (Tuberculosis Cutis?). Presented by DR. EUGENE F. TRAUB.

G. G., a woman aged 47, complained that for somewhat over a year deep-seated, slightly painful nodules had been developing over both lower extremities. From the history of the mode of onset and from the clinical course, her family physician thought the nodules represented erythema nodosum and applied various types of local treatment. The lesions on the left leg disappeared without scar formation, but the lesions on the middle third and the calf of the right leg progressed possibly owing to irritating treatment to the cutaneous surface. The patient was referred to Dr. L. H. Kice, who removed a biopsy specimen and received a report that examination of the tissue suggested mycosis fungoides. Roentgen treatment was given, together with local ultraviolet irradiation, and the lesion gradually healed, leaving a comparatively smooth white scar. The patient stated that she had not taken medicine of any kind in from five to seven years, although she had taken bromides at an earlier period, when she was in a sanatorium for nervous diseases.

Several months ago the eruption on the right leg, which had healed completely, again appeared and has spread rather rapidly. This time the cutaneous surface was involved from the start in what appeared to be a chronic granulomatous process. A biopsy has not been performed on the present eruption, which began on the normal skin between the several scars which marked the sites of the old eruption. The Wassermann reaction was negative. There was a family history of tuberculosis.

DISCUSSION

DR. A. BENSON CANNON: I consider the lesion so characteristic of bromoderma that I should make that diagnosis regardless of whether or not there was a history of ingestion of bromide. A circumscribed verrucous lesion of that kind with a red and bullous margin is much more characteristic of the effect of bromide or iodide than of tuberculosis. I should treat the patient with injections of solution of sodium chloride.

DR. EDWARD R. MALONEY: Now that there is a history of ingestion of bromides at one time, the diagnosis of bromoderma is a logical one. The condition does look somewhat like tuberculosis. It does not look to me like mycosis fungoides, and I do not think it is syphilis. Microscopic examination shows no evidence of tuberculosis. I can make a clinical or histologic diagnosis only of granuloma. I think the diagnosis of possible bromoderma should certainly be entertained.

DR. H. H. WHITEHOUSE: I do not know whether there is any bromide in the system now, but the condition looks to me like bromoderma. I do not see why the roentgen treatment cleared it up, if my diagnosis of bromoderma is correct.

DR. GEORGE M. MACKEE: I examined the slide and did not get much help from it. I could not make a diagnosis of tuberculosis, of syphilis or of mycosis fungoides from the section. All I could see was marked epithelial proliferation such as occurs at margins of old ulcers. The possibility of iododerma rather than bromoderma might be considered, simply because there is no history of ingestion of bromide, and the patient might be getting iodine without knowing

it. I am afraid that it is impossible to make an unequivocal diagnosis. The things to be considered are those already mentioned: a drug eruption, blastomycosis, tuberculosis and even syphilis and mycosis fungoides.

DR. FRANK C. COMBES: I think every possibility has been mentioned and eliminated with the exception of that of bromoderma. The histologic examination showed little except the epidermis, in which were small inclusions of polymorphonuclears, as Dr. MacKee mentioned. I think it would be justifiable to put this patient to the therapeutic test of intravenous injections of solution of sodium chloride and elimination of all foods which contain iodides and bromides.

DR. R. H. RULISON: I am inclined to think this condition is a drug eruption, likely due to bromides. I watched the patient for several minutes. She is a curious person, and I do not believe her word is dependable.

DR. PAUL E. BECHET: There were two distinct rings—a healed ringlike scar where the previous lesion was, sharply demarcated, and the new lesion, which has the same appearance and forms a ring as it extends into the scar of the old lesion. The demarcation seems to me to be too geometric for a drug eruption. I thought it might be a fungous eruption, such as deep tinea. Roentgen therapy in bromoderma would have little effect, but solution of sodium chloride injected intravenously and salt taken by mouth act almost like specifics.

DR. HOWARD FOX: It is well known that the granulomatous type of bromoderma may simulate tuberculosis verrucosa cutis. The absence of the histologic changes of tuberculosis and the spontaneous disappearance of part of the lesion are against the diagnosis of tuberculosis. I should like to know if this patient takes bromoseltzer, as many who state they have taken no medicine fail to realize that remedies like bromoseltzer are medicinal. There are two features which are helpful in the diagnosis of bromoderma. The lesions are often tender, and large numbers of polymorphonuclear leukocytes are likely to be present in the histologic sections.

DR. EUGENE F. TRAUB: The peculiar thing about this eruption was its mode of onset this last time. The original eruption had healed under Dr. Kice's treatment, leaving two flat, smooth, round scars. A few months ago the eruption recurred between the two scars. As it increased in size, it spread about the borders of these scars. This accounts for the rather peculiar configuration. It is also unusual that the eruption disappeared so promptly under treatment with roentgen and ultraviolet rays and that in healing it left such pronounced scarring.

A Case for Diagnosis (Arsenical Keratosis?). Presented by DR. A. BENSON CANNON.

T. M. F., a boy aged 9 years, shows an eruption which was first noticed when he was 6 years old. He had thickening of the skin on the palms and the soles, which peeled off after being present for one month, leaving only redness of the skin on the palms. In December 1936 he had scarlet fever. When his skin started peeling after that disease in January 1937, the skin on the hands, the feet, the buttocks, the elbows and the knees became bluish red, cracked and fissured. The thickening has remained, along with a yellowish color, on the hands and the soles. The patient perspires normally.

The past history and family history were irrelevant. There was no history of the patient's ever having taken arsenic.

Examination shows marked thickening of the skin of the palms and the soles. The skin is yellowish. On the elbows, the knees and the buttocks are large round plaques, 2½ inches (6.4 cm.) in diameter, in which there are numerous pinhead-sized red hyperkeratotic papules.

Laboratory Findings: The basal metabolic rate was + 5 per cent. The urinalysis showed no abnormality. The Wassermann reaction was 2 plus in cholesterolized antigen and negative in alcoholic antigen. The Kahn test was 1 plus, and the Kline test was negative. The Mantoux test gave no indication of tubercu-

losis in January 1937. The blood count showed 84 per cent hemoglobin and 9,900 white cells, and the differential count showed 59 per cent polymorphonuclear leukocytes, 32 per cent lymphocytes, 3 per cent monocytes and 6 per cent eosinophils. Examination for arsenic showed 0.3 mg. of arsenic per hundred grams of dry blood and 0.1 mg. of arsenic in a twenty-four hour specimen of urine.

DISCUSSION

DR. GEORGE M. MACKEE: The condition looks like keratoderma palmare, of the mal de Meleda type. If it were, however, there would not be this history of the disappearance of the eruption. With the finding of arsenic in the blood and the urine, especially if corroborated, one would have to consider seriously the diagnosis of arsenical keratosis. Results of the histologic examination have not yet been reported. I do not think the possibility of psoriasis can be ruled out here. That diagnosis is not likely, but it must be kept in mind. I think the most likely diagnosis is arsenical keratosis. I think Dr. Cannon might well go carefully into the history of this case, because I doubt a little the accuracy of the statement, made by the mother, that the eruption disappeared completely. I wonder if the truth is not that the condition gets better in the summer and that the mother and the child have not observed it, rather than that it disappeared entirely.

DR. PAUL E. BECHET: Much confusion exists on the subject of arsenical dermatoses. A few years ago Dr. Cannon read a paper in which he gave the arsenic content of some of the common foods and fruits, and it was exceedingly high, amounting almost to medicinal doses. If the unwitting ingestion of arsenic by the public at large is as great as Dr. Cannon indicated, there should be a marked incidence of arsenical dermatoses. I should like to ask Dr. Cannon if in his studies a sufficient number of control patients without cutaneous lesions were examined for arsenic. Is the proportion of arsenic greater among persons with cutaneous lesions than in those without cutaneous lesions? Is there a so-called normal arsenic content of the urine? The whole subject presents a practical problem which needs further investigation.

DR. A. BENSON CANNON: My first impression was that this case was one of keratosis palmaris et plantaris, but the wide dissemination of the lesions, their yellow color and the statement made by the mother that the condition began at the age of 6 years, disappeared after one month and recurred after scarlet fever, in January, made me a bit dubious of that diagnosis. I began to search for some other cause and found large amounts of arsenic in the blood and the urine. I went into the question of the history carefully with the mother, and she was certain that the boy's palms and soles were just as clear as her own until after he had scarlet fever. I think the normal amount of arsenic is usually thought to be from 0 to 0.05 mg. per hundred grams of dried specimen. I have been studying the amount of arsenic in diets and the arsenic content of the system in patients receiving special diets and in persons in age groups from infancy to old age, in an effort to determine the normal arsenic content of the human system. So far, I can say that the amount increases with age. Arsenic is prescribed in so many preparations that it is difficult for an adult to know whether he has ever taken the drug. Dr. Maechling does this research for me under the supervision of Dr. Flyn, using the colorimetric system, and this constitutes her entire work. Duplicate specimens from the same patient taken at the same time have been given to Dr. Myers, who uses the March test, and in the main their results have agreed as to the presence or absence of arsenic but not always as to the total quantity present.

DR. GEORGE M. MACKEE: What is the percentage of error in your determination of arsenic?

DR. A. BENSON CANNON: The percentage of error is slight. I do not think I have ever obtained negative results from a test for arsenic in patients to whom

arsenic has been given. The Osborne test has been used to determine the presence of granules of arsenic and its results have checked with those of the quantitative analyses.

DR. R. H. RULISON: Would you be willing to say anything about the spectroscopic test in relation to the other tests? Do they check with each other?

DR. A. BENSON CANNON: I think the Osborne method is a valuable one, and in the great majority of the patients receiving arsenic, granules of arsenic can be demonstrated in the tissues.

DR. R. H. RULISON. I meant the work of Gaul and Staud.

DR. A. BENSON CANNON: I am not familiar with the work of Gaul and Staud.

DR. HOWARD FOX: Is arsenic found normally in a child of this age, and if so, what is the amount?

DR. A. BENSON CANNON: There should be no arsenic at all in the urine of a child of that age, and 0.3 mg. in the blood is high. If the urinary arsenic was higher than that in the blood, I should think that the boy was eliminating his poison faster than it was being stored up and that no treatment was indicated.

DR. EUGENE F. TRAUB: Does sodium thiosulfate cause elimination of the arsenic?

DR. A. BENSON CANNON: Sodium thiosulfate and calcium thiosulfate do effect the elimination of arsenic. I have had many cases in which I have estimated the arsenic in the urine and the blood before administration of sodium thiosulfate or calcium thiosulfate, and there has followed an increase in the metal in the urine and a decrease in that in the blood. In some cases both the blood and the urine have gradually lost all traces of arsenic.

DR. FRED WISE: Would you expect to find granules of arsenic by the method of Osborne if this condition were arsenical keratosis, and would you exclude the possibility of arsenical origin of the condition if they were not found?

DR. A. BENSON CANNON: I should expect to find granules of arsenic in the skin if the eruption were due to arsenic. I can have sections made and stained for granules of arsenic. In arsenical dermatitis, there are often large quantities of arsenic in the areas of dermatitis and little or none just outside the affected areas.

Parapsoriasis Varioliformis. Presented by DR. EUGENE F. TRAUB.

M. M., a woman aged *22*, presents a generalized eruption of about fourteen months' duration, which consists of scaly papules which at times show purpuric manifestations and at other times seem to be varioliform. The lesions appear in crops and run their course in three or four weeks. Some of the lesions seem to persist longer. Ultraviolet ray therapy at one time had almost freed the patient of the eruption, but lately there has been a return, and little or no benefit has been derived from irradiation.

DISCUSSION

DR. FRANK C. COMBES: I agree with the diagnosis. The case was presented for suggestions as to therapy, and I suggest, as I have before, administration of gold sodium thiosulfate and ultraviolet irradiation. I have had 100 per cent good results with those procedures in two cases.

DR. FRED WISE: I healed one patient with massive doses of ultraviolet radiation and one with injections of pilocarpine hydrochloride. The effect was permanent, as far as I could ascertain. I think there is a great variation in the prognosis. Eruptions have cleared without any treatment at all.

DR. GEORGE M. MACKEE: I agree with the diagnosis, and I think that at the present stage of knowledge ultraviolet irradiation is the best form of therapy.

DR. HOWARD FOX: Were the results reported by Dr. Combes permanent?

DR. FRANK C. COMBES: In the one case to which I referred the eruption had been present for about four months. There was a permanent cure in that instance. The condition in that case was treated three years ago. I know nothing regarding the permanence of cure in the other case. It is difficult to evaluate the treatment of this condition because so many patients get well spontaneously.

DR. PAUL E. BECHET: There are variations in the course of the disease. It may lose its varioliform character and appear guttate. I have seen lesions of both types in the same patient.

DR. EUGENE F. TRAUB: This patient was practically freed of lesions at one time as a result of ultraviolet irradiation; then she had a relapse. I have observed a number of cases in which the condition did not clear with any form of treatment and others in which it cleared so promptly with little treatment of any kind, including ultraviolet irradiation, that I always doubted that the treatment was an important factor.

Morphea with Nodular Infiltrations. Presented by DR. PAUL E. BECHET.

F. A., a girl aged 11 years, born in the United States, was first seen on March 16, 1937, with an eruption of three months' duration. Three months previously she had noticed a patch of whitish spots on the right side of the neck. There have been no subjective symptoms. The patch has enlarged since its incidence.

On inspection there is a typical ivory-white patch on the right side of the neck, with slight atrophy and a pinkish color at its periphery. The patch is approximately 8 or 10 mm. in diameter. Scattered through it are elevated yellowish bandlike nodular infiltrations, some of which seem to have undergone fibroid changes.

DISCUSSION

DR. FRANK C. COMBES: I wonder if any one has had any experience with daily injections of gonadotropic substance. Its use has been reported recently to have good results.

A Case for Diagnosis (Erythema Pernio?). Presented by DR. EUGENE F. TRAUB.

J. S., a boy aged 6 years, born in the United States of Italian parents, was first seen on March 18, 1935, with an eruption on the nose of only a few days' duration. There was a history of eczema at the age of 3 months, which cleared promptly with a restricted diet and local treatment. The patient presents an erythematous area on the bridge and the tip of the nose accompanied with slight edema. There is a small area of atrophy. The involved area of the nose feels much colder than the surrounding cutaneous surface. The lesion is said to be most conspicuous in cold weather but can be detected at all times. Last summer a number of boils were present near the site of the lesion, and tiny scars bear evidence of their presence. The total duration of the condition is about two years. The Wassermann reaction was negative.

DISCUSSION

DR. GEORGE M. MACKEE: The condition might be pernio, but more likely it is early lupus erythematosus.

DR. R. H. RULISON: I think the condition resembles early lupus erythematosus.

DR. FRANK C. COMBES: I questioned the mother and she said the child has recurrent boils and pimples on the nose all the time. The nose looks like an area of skin in which there have been inflammatory reactions with some lymphatic stasis and edema.

DR. EDWARD R. MALONEY: I do not see why one would make a diagnosis of pernio in this case. There is no evidence that the condition is due to frostbite. It may be some type of tuberculid, either lupus erythematosus or sarcoid, but I do not know what it is.

DR. HOWARD FOX: The diagnosis of a red patch on the nose frequently lies between lupus erythematosus and sarcoid. In many cases a differential diagnosis can be made with certainty only by histologic examination. The history in this case does not suggest ordinary chilblain.

DR. PAUL E. BECHET: I am inclined to agree with those who consider this case one of early lupus erythematosus. The patch is pinkish. In sarcoid the plaque is more infiltrated and edematous. This one is absolutely flat.

DR. EUGENE F. TRAUB: When I presented this case at the clinical conference of the Skin and Cancer Unit of the New York Post-Graduate Medical School and Hospital last month, the diagnosis of granulosis rubra nasi was suggested; in fact, the majority of the physicians present seemed in favor of that diagnosis. The reason stated was that small beads of perspiration were noted over the erythematous area on the bridge of the nose. The skin on this area felt distinctly cold as compared with the surrounding parts. This condition began about the middle of March two years ago and has persisted with improvement and remissions since that time. When one reads the descriptions in Ormsby's or in Sutton's textbook of erythema pernio and lupus pernio, one is struck by the great clinical similarity. In order to differentiate one from the other, one would have to depend on the microscope or possibly on the knowledge that the patient was or was not tuberculous. The description of erythema pernio given by Ormsby fits the picture presented by this patient exactly. I do not believe that the condition is lupus erythematosus, but I suppose only time or a microscopic examination will definitely settle this point. Dr. Combes has suggested a more likely possibility, but the skin of the nose is colder, not warmer, than the rest of the face, and it would seem logical that in a lymphatic stasis the involved cutaneous area should be warmer, not colder, than the surrounding skin. If the diagnosis of granulosis rubra nasi is excluded, then one is forced by exclusion to accept the idea of erythema pernio, and this diagnosis has seemed the most likely to us, but of course we have seen the child only in the cold weather.

(Drs. Paul E. Bechet, Howard Fox and George M. MacKee expressed the thought that granuloma rubra nasi could be excluded because of the absence of moisture, papules and odor.)

Urticaria Pigmentosa Acquisita. Presented by DR. FRED WISE.

S. L., a woman aged 48, born in Poland, was first seen on March 16, 1937, with an eruption of three years' duration. Three years ago the patient noticed brown and reddish brown spots on the chest and the abdomen, which gradually increased in number. The process spread to the arms, the legs, the back, the buttocks and the neck. There are six brothers and two sisters, none of whom has similar trouble.

Examination showed a widespread eruption involving the chest, the breasts, the abdomen, the back, the legs and the arms and, to a lesser extent, the neck. The eruption consists of discrete macules, varying in color from reddish brown to red and fading to light brown on pressure. The lesions vary from the size of a pinhead to 4 mm. in diameter. When rubbed or scratched, they become urticarial.

DISCUSSION

(The members agreed unanimously with the diagnosis as presented.)

A Case for Diagnosis (Lupus Erythematosus? Sarcoid?). Presented by DR. PAUL E. BECHET.

J. C., a man aged 21, born in the United States, first noticed two months ago a dime-sized lesion near the inner canthus of the right eye, which extended to the side of the nose. Histologic examination showed possible lupus erythematosus. The remains of that lesion have persisted as a small erythematous nodule.

In February 1937 a similar lesion appeared behind each ear. The lesions behind the ears were larger than the lesion on the nose and have continued to enlarge since their development.

On examination the posterior aspect of the pinna auris shows a lesion with firm, raised, continuous periphery. The central portion appears to have somewhat exaggerated cutaneous markings. There is neither atrophy nor scaling. There are no subjective symptoms. The report of the histologic examination of the auricular lesion showed toxic dermatitis.

Radiodermatitis with Multiple Epithelioma. Presented by Dr. Fred Wise.

A. L., a woman aged 50, born in the United States, was first seen on March 2, 1937, with an eruption of twenty-one years' duration. For the past twenty-one years there has been a horizontal band about 2 inches (5 cm.) broad across the abdomen, just below the umbilicus, on which there is marked telangiectasia and atrophy of the skin. During the past twelve months a number of nodules have developed on the lower part of the abdomen and the upper parts of the thighs.

On examination the horizontal band appears like a typical radiodermatitis. The lower part of the abdomen, the upper parts of the thighs, the back and the upper part of the left arm show a number of raised, slightly scaly lesions with pearly borders. The lesions vary in size from that of a match-head to that of a lima bean. The larger lesions are erythematous, and the smaller ones are fawn colored.

Histologic examination showed the nodular lesions to be basal cell epithelioma

DISCUSSION

Dr. Howard Fox: In my opinion, the patient's statement is unreliable. Any dermatologist would testify in court that these changes in the skin could only be produced by roentgen rays and by radium.

Dr. H. H. Whitehouse: I agree with the diagnosis of radiodermatitis.

Dr. George M. MacKee: Not only is the picture classic, but it is characteristic of the radiodermatitis seen thirty or more years ago. I am absolutely certain that the case is one of radiodermatitis. It is not one of poikiloderma or of anything else of which I can think. The multiple epithelioma has nothing to do with the radiodermatitis.

Lupus Erythematosus Disseminatus Acutus. Presented by Dr. Eugene F. Traub.

J. G., a man aged 26, was first seen on March 22, 1937, with a symmetrical eruption of two months' duration on the bridge of the nose and the cheeks. On the forehead, the ears and the sides of the neck there were large and small fixed erythematous patches, with some telangiectasia and superficial wrinkling and pitting of the skin. On the extensor surfaces of the arms and the forearms were small scaly and atrophic lesions. There were areas of alopecia on the scalp and white patches with an erythematous base on the buccal mucosa. The dorsa of the hands showed peculiar violaceous fixed erythematous patches.

The blood count showed 85 per cent hemoglobin, 5,160,000 red blood cells and 3,850 white blood cells, with a differential count of 66 per cent polymorphonuclear neutrophils, 27 per cent lymphocytes, 7 per cent monocytes and no eosinophils or basophils. There were marked anisocytosis and poikilocytosis. Most of the poikilocytes were elongated. There was some achromia. Examination of the urine showed a slightly alkaline reaction but no other abnormality. Medical examination showed rheumatic heart disease, most probably active. The history and physical findings were not suggestive of nephritis. There was a typical history of rheumatic pains in the joints.

DISCUSSION

Dr. Howard Fox: I should suggest that the snake venom test be made in this case, as Dr. Peck is of the opinion that in acute lupus erythematosus it is of prog-

nostic value. The fact that the eruption is confined to the face would not exclude acute lupus erythematosus, as shown by a case which I recently presented before the society (ARCH. DERMAT. & SYPH. **35**:1195 [June] 1937).

DR. A. BENSON CANNON: The diagnosis is confusing to me because the condition seems to me to be a discoid type of lupus erythematosus, with recent acute lesions, and I should predict a favorable outcome if the patient is treated with mild remedies. He has atrophic, scaly, circinate red lesions behind the ears. The lesions are hyperkeratotic, with scales dipping down into patulous follicles. They are present only on the face and neck and in a few small areas on the outer surfaces of the arms. The man does not appear ill.

DR. EUGENE F. TRAUB: My reason for calling this condition acute disseminated lupus erythematosus was that the lesion did not correspond with my idea of the discoid type of lupus erythematosus. Furthermore, in a comparatively few months the patient had a diffuse, rather widespread eruption on his face and extremities. This patient's eruption is only two months old. The lesions are superficial and, I believe, will disappear without leaving atrophic scars or sequelae. However, the prognosis in a case of this type is doubtful. I do not say that it is necessarily bad, but this is the type of patient in whom general septicemia or cardiac or renal complications sometimes develop and occasionally even go on to a fatal termination. This patient has a white cell count of only a little over 3,000, which is certainly not a good sign. He has a rheumatic cardiac condition. His chest is free and clear, as far as tuberculosis is concerned. The fact that there are patulous follicles with some scaling does not make this eruption the discoid type.

DR. A. BENSON CANNON: I think Dr. Fox is correct. I observed a case of acute lupus erythematosus disseminatus in which the primary lesion appeared on the nose and cheeks following a sunburn, the erythema remaining localized for three months. The patient was ill and confined to the hospital, even though nothing abnormal could be found except the redness that resembled erysipelas or erythema multiforme. The lesions finally became general, with effusion into the pericardium and all the joints. Autopsy revealed the typical findings of acute lupus erythematosus—vegetative endocarditis and congestion of the liver and the spleen.

Scrofuloderma. Presented by DR. EUGENE F. TRAUB.

J. A., a man aged 23, born in the United States, was first seen on March 15, 1937, with an eruption of one year's duration. The condition began as a swelling just in front of the left ear and gradually became larger. Then there was a discrete involvement below the original lesion, and evidently the masses were lymph nodes. Four aspirations were made. No incision was made, and no roentgen therapy was given. Two months ago a small opening appeared, and there was daily discharge of a small amount of thick yellow pus.

Examination shows a mass, 5 by 2 cm. in diameter, firmly attached to the skin at the angle of the jaw on the left side. The mass seems to be made up of a number of matted lymph nodes. In the middle of this mass is a sinus, and the surrounding skin is deep purple. Histologic examination revealed a tuberculous sinus. A smear showed no sign of actinomycosis.

DISCUSSION

DR. FRED WISE: I should like to hear later from Dr. Traub as to whether any tubercle bacilli have been discovered or any other confirmative observations made in the laboratory to justify this diagnosis.

DR. EUGENE F. TRAUB: The section which was removed from the fistulous tract was found to consist of tuberculous tissue.

DR. J. GARDNER HOPKINS: I think that finding is often deceptive. A tuberculoid structure appears around old lesions of cystic acne. The old question is brought up here of whether cystic acne is a tuberculous lesion. I could not feel any glands.

DR. EUGENE F. TRAUB: The patient says he had a lump just anterior to the ear. He has been to the Memorial Hospital for the Treatment of Cancer and Allied Diseases, as well as to other institutions, and has seen four or five private physicians. Some type of aspiration, I understand, was attempted at the Memorial Hospital. He has received no roentgen therapy. The condition has progressed downward toward the neck, where it has remained for the short time he has been under my observation.

Erythema Figuratum Perstans. Presented by DR. EUGENE F. TRAUB.

D. G., a man aged 21, born in the United States, was first seen on May 18, 1932, with a generalized eruption of six months' duration. The patient said that the lesion started with an erythematous papule and spread peripherally to form a circle of papules or a solid plaque.

Examination of the nose and the throat was made on June 8, 1932. Transillumination of the sinuses showed no abnormality. The appearance of the nasal mucous membrane suggested mild chronic rhinitis. The pharyngeal mucous membrane was reddened and granular. Tonsillar remnants were infected. Histologic examination in May 1932 showed an erythematous lesion, with much induration. The section showed the epidermis to be normal, with the exception of a few hyperchromatic nuclei in the prickle cell layer. The scaling was nonparakeratotic and thick. There were slight edema and granular degeneration of the upper part of the corium. The blood vessels were somewhat dilated and surrounded by an exudate of round cells. The cellular exudate consisted of lymphocytes only.

DISCUSSION

DR. FRANK C. COMBES: The patient presents an eruption that is clinically either *erythème papulo-circiné migrateur et chronique* of Darier or erythema figuratum perstans of Colcott Fox.

Lupus Erythematosus. Presented by DR. FRED WISE.

LOS ANGELES DERMATOLOGICAL SOCIETY

HARRY P. JACOBSON, M.D., *Chairman*

March 9, 1937

THOMAS W. NISBET, M.D., *Secretary*

A Case for Diagnosis (Linear Lichen? Psoriasis?). Presented by DR. PAUL D. FOSTER.

C. B., a Norwegian woman aged 51, presents a linear group of lesions on the inner side of the left thigh and extending down the inner side of the right leg to the sole, where there is a dollar-sized group of papules. The lesions on the sole appeared vesicular when first examined. A similar eruption appeared four weeks ago on the left arm and the left ankle and extended upward later. Histologic examination showed chronic eczema. The Wassermann and Kahn tests of the blood were negative.

DISCUSSION

DR. SAMUEL AYRES JR.: Cases like this are not common. I have observed two previous cases of localized linear lichen.

DR. IRVING R. BANCROFT: The condition probably is linear lichen, but the appearance is not typical by any means.

DR. PAUL D. FOSTER: This case is rather unusual, in that the linear arrangement of the lichen planus occurs from the axillae to the palm and from the groin at the vagina to the sole. Clinically the papules conform to the picture of lichen planus, but from the histologic study the only diagnosis that could be made would be chronic eczema.

DR. H. C. L. LINDSAY: I think the condition is lichen planus, but I have never seen two lines on the same person. This woman has one on the arm and one on the leg.

(Drs. Halloran, Frost and Robinson agreed with the diagnosis of linear lichen planus.)

Multiple Chancres. Presented by DR. PAUL D. FOSTER.

H. W., an American sailor aged 24, presents numerous chancre-like lesions on the prepuce and the shaft of the penis. There is bilateral regional, as well as generalized, adenopathy. No evidence of a secondary eruption is present. The lesions appeared four weeks ago, seven weeks after the patient had intercourse with a prostitute. The patient states that he had a sore on the penis one year ago, after which he received an intravenous injection. The Wassermann reaction at that time was negative. Dark field examination of material from two of the lesions gave positive results. The Wassermann, Kahn and Kline tests were positive.

DISCUSSION

DR. C. R. HALLORAN: I agree with the diagnosis of multiple chancres.

DR. IRVING R. BANCROFT: I think some of these lesions must be pyogenic infections. This man had an infection from September to December. It might be that the real primary lesion occurred then and that the present condition is the result either of secondary infection or of recurrence in the same place.

DR. PAUL D. FOSTER: This patient had chancroid first and then the chancre afterward. He was recently discharged from the navy. Shortly before being discharged in September he had a lesion which was diagnosed as chancroid. He had about six dark field examinations and the same number of serologic tests, all of which gave negative results, but for some reason the navy physician gave him one injection of neoarsphenamine. The chancroid had practically healed at the time, according to the patient. The present lesions are of four weeks' duration, having appeared five weeks after his discharge from the navy.

Eczema of the Chest, the Arms and the Face. Presented by DR. H. C. L. LINDSAY.

A. B., a white man aged 28, has had an eczematous eruption on the face, the arms and the chest since he was 6 months old. His reactions to all allergic tests are negative. Scratching makes the eruption worse, and for a time it seemed photosensitive, but this winter it has been worse than usual. There was some improvement under foreign protein therapy, and the eruption almost cleared under small fractional doses of roentgen rays. The condition relapsed after a month or so. Since I saw him last he has been married, and his new baby has eczema in the same location.

DISCUSSION

DR. SAMUEL AYRES JR.: It would be worth while for this society to spend a whole evening some time in discussing this condition, which is the greatest single problem in the whole field of dermatology. This patient's eruption belongs in the group of allergic eczemas, and the interesting thing is the seasonal behavior. The condition seems to get worse during the hot weather.

I have observed cases in which the condition invariably got worse in the cold weather in the time of rain and fogs, when there is little, if any, pollen in the air. Some people in the East and the Middle West have eczematous eruptions of the face and the flexures of the elbows which flare up when cold weather appears and at times when there is practically no pollen in the air. During California winters the condition behaves in the same manner.

I don't know how much in the way of scratch testing has been done in this case, but investigation along that line should be as thorough as possible. Unfortunately, the information thus gained is often of little value. The subject either reacts to nearly everything with which tests are made or does not react to anything. Only rarely is therapeutic success attained in this type of case. I suggest nonspecific desensitization by means of calcium thiosulfate intravenously and whole blood or lactogen intramuscularly. In a few cases of this type I have been surprised to see good results follow the application of about 2 per cent yellow mercuric oxide, which suggests a bacterial element. I think a terrible state of confusion exists in regard to this clinical picture, and I should like to hear discussion by other members.

DR. C. R. HALLORAN: This is one of the most troublesome conditions a dermatologist has to handle. It is especially interesting to observe what is apparently the same condition developing in the patient's 6 or 8 month old daughter. I share the opinion that one or many factors may have a bearing on the etiology of the condition. Each subject should be tested for sensitivity to various foods and all external sources that come under suspicion. The patient's home life and habits should be studied; worry or unpleasant family life contributes greatly in some cases. As always, when one is dealing with so recalcitrant a condition, the forms of therapy are legion. When a thorough study of the individual case offers no solution to the problem, as so frequently happens, nonspecific protein therapy in many cases will give good results.

DR. KENDAL P. FROST: Cases of this type present no new problems to the dermatologist. A patient with as severe a reaction as that exemplified in this instance taxes the ingenuity of any one called in to take care of the situation. The fortunate thing is that usually ultimately the condition clears up spontaneously, and one never knows the reason for its clearing.

DR. NELSON PAUL ANDERSON: I feel that I can second the statements of all the speakers, but in addition I think the patient himself has given the clue to the remedy. He said that the only time he had ever been out of the state of California was for two weeks when he was in Oregon, and that during that time he was entirely free from the eruption. Dr. Foster's patient did not get along well in Oregon, but I think this patient would profit from a stay there, and I do not believe that anything of lasting benefit can be done for him in this climate.

DR. WILLIAM H. GOECKERMAN: In regard to what Dr. Frost said, I think efforts will have to be made to progress in the study of this type of dermatosis. I don't think the correct approach has been made up to date. The tendency has been to search for an allergic factor, although voices have been raised more courageously recently for a neurogenic background. I was more than interested by a report made at the last meeting of the American Dermatological Association by Dr. Louis A. Brunsting on a series of carefully studied cases, in a goodly percentage of which the condition was complicated by a distinctive type of cataract (ARCH. DERMAT. & SYPH. **34**:935-957 [Dec.] 1936). In the discussion it was brought out by one of the Harvard group that Harvard ophthalmologists favored the theory that nutritional deficiency was a factor in the production of such cataracts. This was grist in my mill. For a number of years I have strongly felt that in cases of disseminated neurodermatitis there are multiple etiologic factors to be considered. The cutaneous picture is merely symptomatic. In some cases there are allergic, in others neurogenic and in still others nutritional factors. The exact nature of the nutritional deficiency I do not know. I was convinced that deficiency was a factor in some cases by the clinical response of patients

with this condition to a modified Gerson-Hermannsdorfer diet under strict supervision. It should be emphasized that this deficiency need not be observed only in destitute patients at the dispensary. My patients were well-to-do children who had been left to their own whims or the supervision of servants, and it was evident that they had been on imbalanced diets since infancy. It is now my practice to obtain a detailed dietary history, and if a gross aberrance is manifest I place the patient on a supervised balanced diet. The mother is often the least desirable person to deal with in such cases.

DR. H. C. L. LINDSAY: Dr. Ayres got results in a case somewhat similar to this one, which many of the members may remember, by giving pancreatin. I tried to get a determination of sugar tolerance in that case, but the mother of the child refused. Pancreatin was administered by Dr. Ayres, with the idea, I suppose, of taking care of the high sugar content of the blood. Last year a woman who had had the same condition for thirty odd years experienced its cessation after taking 50 5 grain (0.3 Gm.) capsules of pancreatin (panteric, Parke, Davis & Co.). As Dr. Goeckerman has stated, "Find out what the deficiency is and remedy it."

DR. SAMUEL AYRES JR.: My patient, a boy of 6 years, experienced a striking improvement after taking panteric capsules, but they were prescribed not because of any notably high content of sugar in the blood but as an aid to digestion. The patient did have exacerbations of dermatitis for certain definite things to which he was sensitive. At that time it appeared that pancreatin was of great value. It certainly cannot be considered that the chapter is closed.

A Case for Diagnosis (Papillomatous Lesions of the Mouth). Presented by DR. NELSON PAUL ANDERSON.

M. R., an American housewife aged 50, was first seen on May 20, 1935, when she complained of a wartlike growth on the right side of the tongue and a whitish area on the roof of the mouth of about two months' duration. At that time she presented on the right side of the tongue, about 1 inch (2.5 cm.) from the tip, an almond-sized whitish verrucous papillomatous lesion. No teeth were present. Along the margin of the gum on the right side, extending posterior to and involving the buccal reflection, the posterior portion of the right buccal surface and the right portion of the hard palate, was a sharply defined, raised whitish verrucous granular-appearing lesion.

A biopsy specimen was taken at that time from the lesion on the tongue; treatment with radium was begun and continued for four months without any visible effect. In fact, the process during this time spread posteriorly and involved the soft palate. On four different occasions part or all of the involved areas have been destroyed by means of a heavy electrodesiccating current, only to recur within a few weeks. Between 18 and 20 injections of bismuth subsalicylate were given, without any effect. Three different histologic examinations revealed a marked thickening of the epithelium but no sign of any malignant change.

The patient is presented for discussion of the diagnosis, the prognosis and the further treatment.

DISCUSSION

DR. H. C. L. LINDSAY: I suggest the least possible treatment. Patients often get cancer from too much treatment.

DR. SAMUEL AYRES JR.: I have seen this patient from time to time with Dr. Anderson. The condition looks to me more like a verruca with a diffuse papillomatous growth than anything else. It seems that everything ordinarily used to clear such a condition has been employed except solid carbon dioxide. I do not know whether that preparation would be of any help or not.

DR. IRVING R. BANCROFT: I should call the condition leukoplakia with beginning cancer. I have nothing to suggest in the way of treatment.

DR. PAUL D. FOSTER: It looks like carcinoma of the tongue. Syphilis is to be ruled out. I suggest as little medication as possible.

DR. HARRY P. JACOBSON: I am not at all impressed with the possibility of syphilis as a factor in this case. The condition presented is diffuse, erosive and papillomatous, probably benign but likely to become malignant ultimately unless treated. It is possible that a galvanic burn may have played an important rôle in the production of these lesions. This patient has both upper and lower artificial dentures, which are different in color and probably in chemical composition. I believe this fact deserves some consideration.

DR. H. C. L. LINDSAY: I suggest that neoarsphenamine be given for the papilloma. A biopsy specimen has been examined, and nothing malignant appeared.

DR. NELSON PAUL ANDERSON: I should like you to look at the colored pictures accompanying this article by Dr. Walter Howarth of London (*J. Laryn. & Otol.* **50**:28, 1935). The author described the identical condition as a diffuse papillomatosis of the mouth. In the article he reported three cases as instances of precancerous dermatosis—Bowen's disease of the palate and tonsils. I have no doubt after looking at the pictures that my patient and his three all present the same clinical process, although I am not in accord with his conclusions. Howarth destroyed the lesions by cautery, but they returned; he again burned them off and they again returned. At the time when he wrote this article he had had one patient under his observation for fifteen years.

A Case for Diagnosis (Bacterid of Hands?). Presented by DR. SAMUEL AYRES JR.

J. R., an American boy, aged 15, noticed a pronounced red eruption extending along the natural creases of the palms and accompanied with some vesiculation. The patient stated that he had just recovered from "athlete's foot" and had applied gasoline and kerosene to his feet. He had helped to clean a biology laboratory. He says that he has not taken phenolphthalein but has taken pills of aloin, strychnine, belladonna and cascara. He does not recall any trauma.

During the past eight months he has been under treatment for folliculitis of the back of the neck, for which he received fractional doses of roentgen rays and local medication. For the past three or four months he has had repeated colds and sore throats, with which there has been considerable drainage of mucus.

At present the eruption resembles that seen at his first visit sixteen days ago, five days after its onset. Both palms, especially the right, show slight redness along the natural creases, with flaccid and partly dried vesicles but with little secretion. There is slight redness on the backs of the hands. The feet are normal.

Transillumination of the sinuses shows complete darkness of both antrums and frontal sinuses. Cultures from the hands on Sabouraud's medium revealed Bacillus pyocyaneus and some staphylococci.

The patient has received a total of 1 skin unit of roentgen radiation, wet dressings of alibour water (water containing zinc and copper sulfates) and of Castellani's carbolfuchsin dye (carbolfuchsin acetone, resorcinol, boric acid and alcohol) and plain Lassar's paste (zinc oxide, starch and petrolatum) to the hands. There was temporary improvement, followed by relapse.

DISCUSSION

DR. SAMUEL AYRES JR.: Contact dermatitis was considered, but there was no history of handling irritants. Microscopic examination of scrapings from the feet failed to reveal any fungi. The lesions on the palms at first consisted of bright red discolorations along the creases, with superimposed purulent-appearing vesicles in linear arrangement. When these were opened, however, there was little pus in them. The patient has had adequate local treatment for ordinary infections —roentgen radiation, carbolfuschin dye, etc.—each measure being followed by temporary improvement and prompt relapse. I feel that he has an infection of his sinuses which causes repeated sore throats. The tonsils have been removed. This toxic absorption may be causing the eruption on the hands.

DR. C. R. HALLORAN: It is my experience that many so-called treatment-fast conditions will respond to nonspecific protein therapy.

DR. WILLIAM H. GOECKERMAN: Some time ago, Drs. Fred Wise and Jack Wolf published an article in the ARCHIVES (**34**:1-14 [July] 1936) on vesicular eruptions of the hands and feet. In this article they cryptically remarked that the longer and the more carefully a dermatologist has studied such cases, the more time he will require to diagnose a condition. The inexperienced practitioner will readily jump to conclusions. I am heartily in accord with this remark. Pure clinical acumen, although an advantage in forming judgment, will only occasionally lead to a correct diagnosis.

DR. SAUL S. ROBINSON: I agree with the diagnosis. I would suggest the use of staphylococcus toxoid, which I have used in several cases with success.

DR. H. C. L. LINDSAY: Many practitioners are afraid to use any arsenic. Often in some of these chronic fungous infections a little arsenic, in conjunction with other treatment, seems to clear up the condition.

Dermatitis Actinica (Roentgen Rays). Presented by DR. HARRY P. JACOBSON.

This patient is presented to show the results of fairly extensive employment of cautery for the relief of an ulceration involving the lumbar region. He was presented before this section about a year ago by Drs. Moses Scholtz and Max J. Wolff for an opinion as to diagnosis and treatment. The consensus at that time was that the lesion was malignant and possibly the result of radiation. The treatment employed by the colleagues in charge of the patient at that time was varied and extensive and included local applications of Aloe vera leaves.

DISCUSSION

DR. H. C. L. LINDSAY: Did the leaves help any?

DR. HARRY P. JACOBSON: Not at all.

Lingua Geographica. Presented by DR. PAUL D. FOSTER for DR. A. F. HALL JR. (by invitation).

R. R., a Jewess aged 29, a housewife, has had sores on the tongue for the past six months and a burning sensation in the right lower quadrant of the abdomen. The lesions on the tongue have continued to appear in spite of the discontinuance of use of mouth washes, tooth powders and pastes and acid fruits. The presence or absence of the patient's removable plate seems to make no difference. The use of sodium perborate and other mouth washes does not influence the condition.

The patient presents transitory nonindurated inflammatory plaques around the tip of the tongue. Dissimilar metals are in evidence in the mouth, but repeated tests with the microvoltmeter show less than the average difference in the potential (5 to 15 microvolts).

The Wassermann reaction was negative. The blood count showed 4,940,000 red cells, 5,400 white cells and 80 per cent hemoglobin. The differential count gave results of 72 per cent polymorphonuclears, 23 per cent lymphocytes, 3 per cent monocytes and 2 per cent eosinophils. Urinalysis, gastric analysis and a smear for Vincent's organism gave negative results.

DISCUSSION

DR. A. F. HALL JR. (by invitation): The microvoltmeter was used on the patient, and it was found that her mouth showed less difference of potential than those shown by my mouth and by the mouths of others working in the clinic. A tentative diagnosis of geographic tongue was made, but because of the severe subjective symptoms it was thought worth while to present the case here.

DR. SAMUEL AYRES JR.: I agree with that diagnosis and in view of the patient's discomfort would advise fractional doses of roentgen rays. In a number of private patients who had had this condition for a long time it cleared up quickly under six or eight doses of one-fourth skin unit of roentgen radiation.

DR. H. C. L. LINDSAY: I have cured the condition in some cases with roentgen rays.

Leprosy. Presented by Dr. Harry P. Jacobson.

This patient, a married woman aged 41, was born and raised in Mexico, and came to this city about fifteen years ago. She presented herself at the office because of a limited cutaneous eruption involving the dorsal aspect of the metacarpophalangeal joint, the radial aspect of the first phalanx and the ulnar aspect of the last phalanx of the left index finger. The eruption began approximately eight months prior to her first visit to the office, three days after a roentgenogram of the wrist was taken because of an accident to the palm several days before. About two months after the injury, numbness of the left index and middle fingers set in. The attending physician (an osteopath) treated the patient from the day of the injury until she came to this office. The treatment, according to the history, consisted of application of ointments and diathermy locally. In spite of these treatments, "blisters" continued to develop at intervals on the involved extremity without any obvious reason, and numbness steadily grew worse. Several weeks ago her physician made a "blood test" and told her the results were negative. The patient is a needleworker on a power machine, and relies mostly on the use of the involved fingers in her work.

Examination reveals an obese woman of average intelligence, anxious to cooperate in arriving at a proper diagnosis of her condition. There is a nonelevated, fairly marginated, erythematous, roughly circular plaque on the dorsal aspect of the metacarpophalangeal joint of the left index finger, approximately 0.5 cm. in diameter. Another similar but somewhat infiltrated lesion, 2.5 by 1.5 cm., with a damaged epidermal covering, occupies the radial aspect of the first phalanx of the same finger. The color of the lesions varies between bright and dusky violaceous red. All the lesions, as well as irregularly distributed areas over the dorsum of the hand, are markedly anesthetic. The postauricular and ulnar nerves are not definitely palpable.

Nasal smears taken the day of the first examination and the following day revealed the presence of numerous acid-fast rods in each of eight slides prepared. Cultures made from the nasal secretion on Loeffler's medium, to eliminate the possibility that the acid-fast rods belonged to the diphtheroid group of acid-fast organisms, proved negative. Bloody serum, obtained through blistering with solid carbon dioxide one of the lesions on the index finger, revealed numerous acid-fast rods similar to those observed in the nasal secretion. The sedimentation time was fifty-eight minutes.

DISCUSSION

Dr. William H. Goeckerman: I think the presenter is to be highly commended for suspecting leprosy in this case. I have observed enough cases of leprosy to realize that the clinical manifestations may be as varied as those in syphilis or tuberculosis. I think this is a good diagnostic feat for this section of the country, where leprosy is seen only occasionally.

Dr. Samuel Ayres Jr.: I think this brings up an important point. Some years ago I suggested that this society go on record against the present method of handling leprosy in this state and take up with the California Medical Association or the proper authorities the desirability of humanizing the laws concerning lepers. This case furnishes a good reason for following this procedure. The Chamber of Commerce would probably like to have the physicians who have seen her say the patient did not contract the disease here, but she has lived in California fifteen years and has had the disease a comparatively short time.

Dr. Nelson Paul Anderson: The laws of the state of New York allow lepers to be at large provided they report regularly for treatment. This woman has no open lesions. She is not in an ulcerative mutilating stage of leprosy, and I think for the purposes of protection one could well make one's records read tuberculosis or sarcoid and treat this patient with chaulmoogra oil, with the proviso that if at any time she drops from sight or if any open lesions develop she be reported.

DR. SAMUEL AYRES JR.: I do not think this question has been solved. I have often wondered what I should do if a person close to me should acquire this disease. It is a serious problem. The state of New York has a parole system which allows leprous patients to be treated by private physicians or in clinics, and this state has a barbaric system of incarceration. I think the question probably deserves more discussion. Probably a committee should be appointed to make some investigations and recommendations.

A motion was made and seconded that a committee be appointed. Drs. Ayres, Goeckerman and Caskey were chosen.

Book Reviews

Arsenicum bij Psoriasis en Arsenicodermie. By Robert Simons. Pp. 50. Leyden: A. W. Sijthoff.

The author investigated the effect of arsenical medication in 160 cases of psoriasis. Arsenic was administered as arsenic trioxide in pills containing from 1 to 5 mg., given 3 times daily, and as solution of potassium arsenite in doses of from 5 to 25 drops, 3 times daily. Signs of intoxication, such as conjunctivitis, diarrhea, nausea and weakness, were not considered indications for reducing the dose or discontinuing treatment unless they were severe.

The results of this investigation led the author to conclude that treatment with inorganic arsenic does not effect permanent cure of psoriasis. Temporary involution can be produced, but this is of short duration and accompanied by signs of intoxication. Recurrence cannot be prevented by resumption of the arsenical medication. In about 30 per cent of the cases new lesions of psoriasis appeared during treatment. With few exceptions, all the patients showed signs of arsenical intoxication, particularly when the arsenic was administered for more than two months. Children seemed to tolerate the drug better than adults, and the eruption responded more effectively to the treatment, but it usually recurred, often in a more severe form than the original eruption. The same ineffectiveness of arsenical medication was observed in cases of old and of early involvement. Psoriasis on favorite sites such as the elbows and knees responded less favorably than that situated on the flexor surfaces. In some cases psoriasis of the scalp reacted favorably; in other cases it was more obstinate to treatment than an eruption on the body. Lesions of nails were not influenced by treatment. In conditions of the arthropathic type improvement was noticed in the arthritis but not in the psoriatic eruption.

The author concluded that arsenical medication is ineffective in the treatment of psoriasis.

Les médications dermatologiques. By Georges Levy. Price, 45 francs. Pp. 240. Paris: Gaston Doin et Cie, 1937.

The author has compiled an orderly study of dermatologic therapeutics, the obtaining of material on which in the past has required the student to consult many textbooks and systems of dermatology. Treatment of specific diseases is avoided. In the introductory chapter Levy discusses briefly the general action of topical applications and the skin as a physicochemical membrane and attempts to link the recent biologic investigations of the chemistry of the skin and therapeutic procedures. The general outline of presentation is that used by Darier in his *Précis de dermatologie*. In the first chapter he discusses the types of pharmaceutic preparations for local applications, including solutions, emulsions, powders, fatty substances, plasters and varnishes. The next covers the active drugs commonly used in dermatology and their manner of use. The third chapter deals with cleansing and soothing agents; anesthetic, antipruritic, keratolytic and reducing agents, and rubifacients, depilatories, bleaches and caustics.

In the section on internal therapy is included a chapter on the Gerson and the Sauerbruch-Hermannsdorfer diet and the dysvitaminoses. Under this heading are included brief chapters on vaccine and serum therapy, nonspecific protein therapy and desensitization. The book should be useful to students and teachers of postgraduate dermatology.

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DECEMBER 1937

PUBLISHED MONTHLY BY AMERICAN MEDICAL ASSOCIATION, 535 NORTH DEARBORN STREET, CHICAGO, ILLINOIS. ANNUAL SUBSCRIPTION, $8.00

Entered as Second Class Matter Oct. 30, 1917, at the Postoffice at Chicago, Under the Act of Congress of March 3, 1879

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